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Proceedings of the 6th European Music Therapy Congress

David Aldridge, Jörg Fachner & Jaakko Erkkilä



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CHAPTER 1

*Foreword - EMTC
Proceedings*

Erkkilä, Jaakko

**Chair of the Organizing Committee The
6th European Music Therapy Congress ,
Finland**

It is my pleasant task to write the foreword for these proceedings. When looking at the papers included, a warm memory of the congress emerges once again. Glancing through the publication is also a journey where new discoveries can be made. When it is not possible for a participant to attend everything in the congress but to make difficult choices between many interesting sessions, the value of this kind of high quality proceedings really comes up. Like the previous electronic proceedings by Musictherapyworld/UWH, I suppose that this also soon redeems its place and will be widely used wherever music therapy is in the focus of interest. Undoubtedly, many new field-specific openings can be found thereof as well.

Some may have critical thoughts about digital publications and may long for traditional paper copies instead. This is understandable but when we think of all the benefits of an electronic publication for a specific discipline such as music therapy, it is easy to advocate it too. Text, colours, audio and video can be included and thus, many essential phenomena and contents of the profession – often hard to describe fully by words – can be illustrated.

The meaning of a congress for a profession is manifold. From a presenter's point of view it may be a unique opportunity to share one's findings, whether practical or theoretical. Some time ago I attended a seminar where many music therapy doctors met. A common opinion among the participants was that it takes rather long after the defence, before one really is able to condense a thesis into a relatively brief presentation or article. It is because it takes time until a researcher gets rid of the details and is able to crystallise the essential core of his/her dissertation. However, this is not only an issue of time but requires hard work as presentations, articles, lectures, etc. as well. For many attendees, preparing and presenting congress papers seemed to be an important role in the process of discovering the essential content of their work. Thus, presenting at the congress is not only sharing the ideas but developing one's thinking. The latter relates to clinician presenters as well, I think.

The title of the congress – “Many Faces of Music Therapy” – refers to a plurality of ideas within the broad field of our profession. The title also symbolises the hidden aim of the organizers to be inclusive and not exclusive. Unfortunately, it seems that the decision makers in many countries do not share this kind of inclusiveness with us. There is an increasing pressure to be able to clearly say who we are and who we are not. In some countries this means that much effort is required in order to connect music therapy to the health care system and to gain recognition this way. Anyway, more evidence is required and the concept of professional divergence is often challenged. How many faces we can have in future, is a crucial question for music therapists. In this situation where we feel insecure - at least now and then, the

meaning of international collaboration and brainstorming is very important. Thanks to the EMTC and the Musictherapyworld we have a forum for them!

Have nice moments with the publication,

Jaakko Erkkilä

CHAPTER 2

*KEYNOTES OF THE
6TH EMTC
CONFERENCE*

*Music as a possibility of
chance – healing
metaphors in music*

Lehtonen, Kimmo

**Keynote 1 at the Opening Ceremony on
Wednesday, June 16th, 19:45-20:30**

Visions, scenes and dreams – Jungian archetypes in music

This article is based on the meaningful moments described in stories of Finnish life histories and the specific pieces of music related to them.

The theoretical background is based on the psychodynamic theory of music and meaning as a transitional object. The author assumed that different pieces of music promote and facilitate the psychic work of the individual during traumatic life situations. In this working through process the suffering individual can bind (Reichardt & Ikonen 1990) his or her traumatic and painful psychic tensions as well as the original contents of these traumas with music. In addition, music helps to resolve and act as a catalyst for healing.

The binding process means that the psychic tension or anxiety diminishes while its restless psychic energy gets bound in the creative musical experiences. During this process, musical pieces get loaded or associated with psychic energy. This process gives these helping pieces of music a constant (transference like) energetic meaning, which is also recognizable in the later phases of the life span. This also means that such pieces of music act as “memory anchors”, or triggers which contain important meanings bound to these traumatic and helping life experiences. This is quite obvious for therapists who work with the elderly.

Many pieces of music act like a transference and they immediately arouse strong memories, emotions and mental pictures from listeners’ distant childhood or other meaningful moments in a client’s life. This also happens with demented people, who still have their memories but the process of getting in contact with them is disturbed or difficult. A certain piece of music can remind them of many vital memories of different persons and especially social interaction with meaningful persons. These experiences are often described as follows :

“This is a song which my mother used to sing, when I was four years old (Somewhere over the Rainbow). I was sitting in her lap and there was this specific feeling of togetherness. Soon after my mother died and I was thinking that I can never be happy again. That is why this is my mother’s song. Every time I hear it I feel this same old nostalgic togetherness. I am happy and sad at the same time”.

Music can express so-called “mixed feelings” – it can be sad and happy at the same time. These kinds of experiences are also familiar for clinical music therapists. A few years ago I became more aware of them when we (with my colleague Merja Niemelä) were conducting research on the most meaningful pieces and the mean-

ingful musical experiences of Finnish hospitalized psychiatric patients (Lehtonen & Niemelä 1997).

We collected pieces from every large mental hospital in Finland by asking psychiatric patients to write a list of the ten most important pieces of music. At the end of the investigation, we got a list of thousand pieces of music. After that we analyzed the most meaningful 25 of them. In our analysis we soon found out that it is important to pay attention especially to the metaphoric structures found in these most meaningful pieces.

We discovered soon that these pieces of music were strongly anchored to the most meaningful life experiences of these psychiatric patients. For example:

“I was listening to this piece over and over again during my despair after divorce and thinking about killing myself. – The words tell a sad story about a lonely girl who is standing on the bridge staring at flowing dark water underneath”.

Many of the pieces investigated contain sad stories about personal problems, loss and mourning. The songs were loaded with particularly strong Jungian (Jung 1978) archetypal metaphors. The strongest and most important archetypes seemed to be related to water; crossing a water or river, seashore or on a bridge.

According to C.G. Jung (1978) these are the symbols of transcendence. They symbolize a radical change between two phases or places; life and death, happiness and despair, health and illness and so on. The vast majority of the pieces were Finnish songs written in minor scales. Only one of the songs investigated were in major scale and it was “Yesterday” by the Beatles - a sad song which is hard to recognize as a major piece.

The majority of the pieces represent Finnish popular music from different decades from the 1950’s to the present day. The metaphors of Simon & Garfunkel’s favorite piece “Bridge over Troubled Water” (words and music by Paul Simon) are a fine example of the genre.

When you’re weary
Feeling small,
When tears are in your eyes,
I’ll dry them all,
I’m on your side
When times get tough

And friends just can't be found.

Like a bridge over troubled water,

I will lay me down.

Like a bridge over troubled water,

I will lay me down

These songs tell touching stories about grief and suffering evidently belonging to all human life. Many of them seem to say also that the suffering individual is not alone and there will always be somebody who is going to lend a helping hand or who is on one's side.

These meaningful pieces seemed to give a suffering individual hope by giving an empathetic promise that somebody has already gone through the same kind of hard times and even the most severe problems can be solved.

This is often referred to as "validation" – the idea that others have shared the same suffering. Nietzsche has said "How much suffering there is to go through".

The other interesting example is the song "Don't Give Up" written by Peter Gabriel:

...got to walk out of here

I can't take any more

Going to stand on that bridge

Keep my eyes down below

What ever may come

and what ever may go

That river is flowing

That river is flowing

Don't give up

Cause you got friends

Don't give up

You're not the only one....

The same types of metaphors are repeated in these healing songs. No matter which decade they represent, these important songs give hope and have helped the suffering individual to calm down and work through their strong emotional problems, which could not be handled otherwise.

These pieces seemed to contain metaphoric meanings which are easy to relate to a listener's personal suffering and difficult, emotionally charged life situations. The metaphors seemed to translate inner feelings and emotions to personal mental pictures, which are helpful to the individual to start and carry on his/her psychic work. The key is to identify a song's narrative characters and metaphoric stories.

There were also other kinds of metaphors which seemed to represent different aspects of traumatic experiences. In these songs we find people who were wandering in the foggy landscape trying to find their way home. There were ever changing shadows and light (i.e. Yesterday: I am not half the man I used to be – there's a shadow hanging over me) and one of the most important archetypal female figure "anima", (i.e. in the Eagle's famous piece "Hotel California": a woman with a candle in her hand) which could be found in almost every healing song.

According to Jungian analytic psychology, the shadow is a main symbol of the unconscious. According to Jung, consciousness is like a spotlight which while throwing light to some objects or places at the same time leaves (unconscious) things in shadows.

These meaningful songs act just like the "Jungian spotlight" because they seem to lead one's attention to the unseen possibilities or resources of his/her own. It is obvious that these songs have a close relation to the human unconscious. We could say that these songs form a dreamlike road to the unconscious. They also help individuals to integrate unconscious and archetypal symbolic material relevant to the conscious mind.

Following this investigation we become even more interested in Jungian analytic psychology and symbolism. Jungian archetypes and their relation to music and musical expression are seldom discussed in the theoretic discourse of music therapy. This is a bit strange because Jung himself has once said: "Music is irritating me because musicians are handling very deep archetypal psychic material without being aware of this." As well as If I could live another life I was going to become a music therapist. Although Jung wrote lots of books and articles about art and artistic symbolism, he hardly said a word about music and its relation to archaic symbols and archetypes of human mind.

Perhaps this is why Jungian analytic psychology, archetypes, synchrony and collective unconscious have remained as an unwritten page in the “theory book” of music therapy. So after these perceptions I started to systematically investigate Jungian theory and archetypes and it started an on-going research project of meaningful life experiences and music. I will explain this investigation in the next chapter.

Nothing Else Matters – Music as a means of working through traumas

I was thinking about the research design and I decided to use music as a means of activating the research group’s imagination and memories with a suitable piece of music and after that to ask them to write down their meaningful life experiences and music as it related to them. The idea was to use qualitative phenomenographic method based on the grounded theory. I am interested in research groups’ experiences such as they describe them. I tried to avoid giving examples or instructions which could be too leading. I also tried to investigate the stories without inordinate theoretical assumptions.

At present I have collected almost 300 different stories about the meaningful experiences and related music. I have adopted a narrative diary writing technique developed by Jungian analytic psychologist Ira Progoff (1973, 1975, 1980) with a piece of music I found optimal for this purpose.

Progoff’s original idea is based on the Jungian theory of the collective unconscious. The collective unconscious deals with the symbols which are shared by all the human beings no matter that culture they come from. Jung writes about the archetypal symbols what are common in our dreams, myths and fantasies. These symbols are also an essential part of music and metaphors found in texts of songs and they are often loaded with psychic energy. According to Progoff’s method people first write down things and share ideas through their biographies.

In the second phase they discuss their findings and the third phase gives them an opportunity to deepen their findings by combining them with their dreams, fantasies and metaphors. After that, these entities are written down in the diary and they are re-experienced and expanded. The main idea is that the writers experience, not analyze these stories. In my technique I only used the first phase in order to see what kind of music and meaningful life experiences link together.

This research also owes much to Dorit Amir's (1988) theory of meaningful moments in music therapy, which means that during these moments something is changing or has been changed in a client's life. According to Amir (1988) the meaningful moments are an essential part of the inner life of a client. It is a music therapist's task to create the right process and atmosphere from these kinds of sudden experiences. In Amir's theory, these moments are closely related to the music therapy process, but my idea is to examine them as a part of the human life experience by taking a broader perspective to them.

Freeman (1999) writes about "crystalizing experience" which means a meaningful experience when an individual suddenly becomes aware of the most important things in his/her life. According to Freeman these experiences affect in many ways the person's self-concept and comprehension of his/her possibilities and resources. These experiences can occur in childhood but most often they are an essential part of crisis in youth or young adulthood years when a person's identity is growing and developing.

I asked people to follow these steps:

1. Close your eyes and think about your life,
2. Think about the most important turning points in your life, where your life radically changed,
3. Think about the situation and collect associations and mental pictures related to it and write them down by using for instance mind map technique.
4. Think about what music comes to your mind and write down the name of the band or artist and the words you can remember,
5. Think about the situation which came to your mind, were you alone or did you have company, why this is important, what things were changed and what kind of consequences this situation had for your later life.

I used a particular piece of music recorded by the Finnish heavy metal group Apocalyptica, which plays heavy rock with four cellos. I chose this particular piece which I found optimal for the purpose for certain reasons. The piece was a cello version of the heavy rock band Metallica's well known piece, "Nothing Else Matters", which I had used already several times with my students. This particular piece of music was selected also for its paradoxical nature. It is originally a heavy piece with lyrics, but the version I used is performed by using the instruments and style of the classical music and performed as an instrumental version. I also expected that some of the persons can recognize the piece and remember its words and of course, some of the listeners already have different memories attached to

this piece of music. I also thought that the name of the piece (which I did not tell to listeners) could arouse emotions, memories and mental pictures. Actually the original "Metallica version" is a very severe and quite sad love song. To me the Apocalyptic's version represents a healing sorrow (Klein 1929) in its pure form.

The results were enlightening and expected. "Nothing Else Matters" brought tears to many listeners' eyes and it suddenly opened a wide field of mental pictures and memories.

Most of these experiences were traumatic and quite similar in nature. Many of them can be described with the same kind of metaphors. I ranked listeners' most meaningful life experiences into the four main themes, which represented memories from:

- 1) the lost idyll of childhood,
- 2) the first love or getting a baby,
- 3) the feeling of despair and mourning related to losing a beloved person
- 4) the experience of finding a new life direction, growing individuality and integration. These themes were not separate but usually many of them were represented in a single story.

The first theme: The lost idyll of childhood

The stories of the first theme told about early childhood experiences when everything was safe and sound. It was a nostalgic and perhaps a little bit regressive theme which was leading to the lost paradise of childhood. The stories told about happy childhood years "when sun was shining and sky was blue" and all the troubles seem to be far away. There were also shadows in that paradise because most of the writers said that this paradise did not last forever and they suddenly have to face another kind of reality. I'll give you some examples about these happy memories which often dealt with Christmas songs and experiences, singing experiences and feeling of togetherness with siblings and grandparents, and nice and happy sunny days in the country.

Often these happy experiences were in sharp contrast to the troubled and chaotic experiences after them. I called this theme a "lost idyll of childhood". Music –

especially Christmas carols and childrens'songs provide a close contact to such moments.

“The birth of my son and daughter – being a woman in its full meaning for the first time, warmth and love. Giving birth to the most beautiful child...and then a divorce – like a hit in my face - in 1997...after that I suffered from a serious depression...being left out, living without laughter and singing for years. I was feeling like being in a black hole. I remember this time every time I hear this Finnish piece: “We did everything we could.”

“My mother died when I was four years old. Her song was “Here under the North Star”. I am sitting in her lap in the old wheel chair. I sang this piece many times before I learn to understand that my mother is dead. When I began my university years my grandmother died and I had the same feeling... (A Finnish piece: Guardian Angel). When my grandmother died I was so lonely and sad because I had nothing but the dead mothers. I was afraid of the future. My life changed but I was not ready for those changes”

“It was this old piece “Warum” (Why) by Miliza Korjus which was quite popular in Finland. I see myself walking in the woods hand in hand with my mother. The sun is shining and I see and almost smell those big pine woods around us. I am so happy... My one-year old sister suddenly died when I was eight years old. After the funeral we children started to play. In the evening my father had been drinking and he came home, thus he has promised not to drink anymore. I think that this evening was the end of my childhood.”

“When my little sister was born, mother didn't have time for me anymore. So I was very lonely and I try to give consolation to myself by masturbating. I was so lonely and this same loneliness has followed me through my entire life. It was Chopin's sorrow march played at my little brother's funeral. It was just a symbol of all the sorrow and pain which have always been a part of the life of my family.”

The main idea of this theme is described as the well known “Vanitas” thought. In human life there is nothing permanent and everything just vanishes.

The second theme: Standing on the brink of a deep abyss

The next theme is also connected to the dialectics of human growth. One had to move from one stage of development to the next without a decent maturity. This is the central existential theme of human life - you have to move over - no matter if you are ready for it or not.

I called this theme a “theme of transcendence” according to Jungian analytic psychology.

“I am sitting in a train which goes from Pori to Helsinki (two Finnish towns). It is a Sunday evening and there is dark outside. The fear and anxiety is growing in my mind. I am sick and tired of my parents divorce, my father’s heavy drinking and so worried about my little brother who is about to brake down at any moment. I sit in the train, lean to a window and I am crying all the time. I feel that the only thing which is permanent in my life is the steady noise of rails and sounds of engine blows ...the piece is performed by Helene Basin: I was left out, they closed the door in front of me... When I think about this time I understand that it helped me to grow up and it was the way to independence.”

“I am sitting on a sofa. I feel bad and guilty because I can not open myself in a music therapy group. I have always been afraid of people and that is why I am not able to tell them about myself. Then I opened the radio on and there it is: ‘If you wish you can fly, if you believe you have wings...when you look at the mirror you can see your enemy...this piece gave me enough strength to open up and tell about my problems in my music therapy group. It just suddenly happened when I realized that everything depends on me and my old mistrust and fear.”

“I was coming back from the hospital where I was there to meet my dying father. The next day they told me that I don’t have to come anymore because my father died in the night. I felt my mother’s helplessness and self-pity so awfully that I had to hide my pain from the others. Suddenly a piece of music came to my mind. It was “ We Gotta Get Out Of This Place (The Animals). So I left my home a week after father’s funeral.”

And the well-known lyrics goes like this:

“...Watch my daddy in bed dying’

Watched his hair turning grey,

He’s been workin’ and slavin’

his life away

Oh yes I know it...

We gotta get out of this place

if it’s the last thing we ever do

We gotta get out of this place

cause there is a better life for
you and me...”

The other story goes like this:

“I could not get a child and we were trying and trying with my husband. I was so sad and lonely. During evenings I was playing my piano and I played very often the same piece, Rolling Stones’s AS TEARS GO BY...”It is the evening of the day. I sit and watch the children play. The smiling faces I can see but not for me”...Suddenly I noticed that this piece tells my own story. By playing it I was unconsciously working through our problem and soon after we decided to adopt a child.”

The sun is going down and I was sitting in my room. I have just begun my studies in a big foreign city far away from home and friends. I got an empty feeling, I have lost my direction and I feel there is no place to go. It is quiet and I am afraid of the future and this feeling makes me just stand still. I miss my girlfriend, friends, parents and my old neighborhood. I feel sad and the sadness is getting its expression in a song that came to my mind...The song was Pink Floyd’s WISH YOU WERE HERE:

Oh how I wish, how I wish you were here

We’re like two lost souls swimming in a fishbowl

Year, after year....

The third theme: being on the bottom of the abyss – From deep down I am calling you Lord

This theme is usually connected to experiences which have deeply twisted the basic trust of the individual.

“I was thirty years old when my husband suddenly and without warning left me. I was alone with three little kids. I was so hurt and lonely. In the evenings after I took the children to bed I was listened to a lot of music, which gave me consolation and hope. I felt I have to be strong because I did not have other alternatives. I was listening especially to the ADAGIO by Tomaso Albinoni and AIR by Johan Sebastian Bach. Those pieces gave me enough strength to carry on.”

The life-stories represented existential depth underlining the constant tragedy of changing happiness and loss or light and shadows in human life. These experiences

were very strong and sudden and they seemed to be related to the Jungian archetypes and synchrony.

These experiences were often described in a way that somebody who is suffering is sitting alone and then he/she hears a song from for example the radio, which is telling his/her story. Usually they were the metaphors, which say that you have enough strength to solve your problems and there is a way out of despair and it is only you who can make a change. Music and songs seem to have this kind of function because music says much more than mere words. Only songs relate bodily meanings and unconscious emotions and words together. This gives the suffering individual "a symbolic distance" to his/her problems. Music shows new possibilities and gives extra energy for the psychic work needed to solving problems. Particularly songs were important because they seem to give words to experiences which a suffering individual was not able to describe with words. In a way these healing metaphors in songs seem to form a high road between mind and matter as Jung (1973a, 1973b) describes the phenomenon.

About the iconography of the stories

These experiences usually happened in situations when somebody was alone and had to stop and face problems and him/herself. The symbols of the mental landscape were full of melancholy and depression. The metaphors of the stories were those were taken from sad songs:

"darkness, emptiness and thick fog everywhere...I can not find my way home. I noticed afterwards that I lost music for two years. My life was just like those dark grey winter days."

"babbling of the fountain in dark and gloomy park of the city hall. I am drinking wine from the bottle and looking at the cold water drops glowing in darkness."

"there is cold spring wind blowing outside, trees without leaves."

"I am standing alone on the church bridge and looking down to the water and watching how black water is trying to find its way in the icy river bed."

The stories also told about the process where losses in earlier life phases are reactivated and repeated in later life experiences - one must often move from one phase of life to another without sufficient maturity. Music seems to play a very meaningful and important role in working through these experiences. Music gives hope,

consolation and new ideas in the hard, difficult, emotionally trying situations of life. In this sense music also functions as an important means of self-healing.

The meaning of music is based on moving and flexible cathexes (psychic energy) of the human psyche, which help the individual to bind his/her anxiety and restlessness in musical objects. So this is some kind of a shortcut to my research project. I am very honoured and proud because I could write to your new journal and I wish that Finnish music therapists could continue this kind of collaboration with our Canadian friends and colleagues.

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Author information

Kimmo Lehtonen (born 1955) is a professor of education in the University of Turku. He is one of the pioneers in Finnish Music Therapy. His doctoral thesis, *Music as a Promoter of Psychic Work*, was the first in Nordic countries. Lehtonen also teaches permanently in the Sibelius-Academy and in the University of Jyväskylä as well as in the polytechnics which have music therapy training in their program. Lehtonen is a widely known Finnish music therapist who has published several scientific articles and monographies in 7 languages. At the moment Lehtonen is particularly interested in music education as therapy and meaningful musical experiences during lifespan. Lehtonen is still working clinically in the Family rehabilitation Center of Turku one day per week.

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*Hidden music - an
exploration of silences in
music and in music
therapy*

Sutton, Julie

**Keynote 2 on Thursday morning, June 17th, 2004,
09:45-10:30**

To focus on the phenomenon of musical silence is analogous to deliberately studying the spaces between the trees in a forest: somewhat perverse at first, until one realises that these spaces contribute to the perceived character of the forest itself, and enable us to speak coherently of “dense” growth or “sparse” vegetation. In other words, silence is not nothing. (Clifton, 1976)

While we have not really written about or researched the silences we experience and share in the music therapy room, it is not because we have not thought about them. And so, from the beginning, I want to thank the following people, who have contributed to this presentation in different ways, through their various dialogues with me:

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What follows are thoughts and reflections about silence in our work, informed by listening to music inside and outside the therapy room, through dialogue with colleagues, and by reviewing the literature. I focus on music, the centre of our work, and weave a path between the silences and sounds of music and music therapy. I also touch on several concepts of silence, including: silence and nothingness; silence and death; silence as absence and presence; silence as an active agent of change; and finally, silence as a hidden music.

An old british superstition states, that if there is a sudden lull, or silence, in a conversation, it is believed to be caused by an angel passing by¹. Of course, I realise that other superstitions from my home island also include placing baby teeth under a pillow for the fairies to exchange for money; nonetheless, I ask you to try to hear the examples of musical silences as if they are indeed angels passing by. By this, I mean, to listen to the silence as it occurs, and also as an entirety. This means resisting the urge to count silent bars, or listen for sounded reference points. If possible, attune to each silence for its own sake, as it passes by.

To tune our ears to this task, and towards music itself, here are two examples, firstly, some drummers using silences as a way of making changes to the ongoing flow of the music. Texture and pacing can alter after each brief silence, perhaps

1. Roud, S. (2003) The Penguin Guide to Superstitions of Britain and Ireland London, Penguin Books, pp452-3

offering preparation space for the musicians, as well as providing some unpredictability to catch our attention.

[PLAY NEW YORK DRUMMERS] Track 1

This example contrasts well with the next, which reveals one way in which silences can engage us in a new task of listening, during the beginning of a musical work. Here are the first sounds from the extended form of a large-scale piano sonata. One basis of the sonata's first movement is an elongated melodic line, here barely stated before it is interrupted by silence. The unexpected absence of sound re-tunes our ears, and as we seek out the next sound, we wait to see what will happen.

[PLAY OPENING BARS OF SCHUBERT B-flat Sonata] Track 2

The uncertainty about what is happening, and what might happen, are a feature of Schubert's opening to this sonata, and they remain one of the characteristics of the music throughout. There is already a sense that these silences are not merely interruptions to the flow of the sounds, or a means of catching our attention, but that there are more significant and complex roles and functions involved. And, it is how musical silences occur and what processes might be contained within them that I will now explore, in both music and music therapy.

Silence and nothingness

(read by Jaakko)

It is the "somethingness" that we usually attend to in music, not the "nothingness", and yet the uses of silence are numerous: silence may be mere punctuation or a minute interval between two articulated tones. It may be short or long, measured or unmeasured, interruptive or noninterruptive, tensed or relaxed. But in one way or another the silence becomes a part of the music. (Rowell, 1983, p.26)

Here, Rowell makes a case for considering silences as integral to a musical work, citing several different ways in which silences are as important as sounds. Silences occur between notes within a melodic string, they mark different punctuation points during the played-out life of a piece, they can interrupt the musical flow, or provide a more relaxed, slower-moving space. In the next example, from plainsong, the silences that occur also appear to serve different functions. First, there is the reality of the necessity to breathe. Yet, this has been formalised into the structure of the

music, marking musical phrases and parts of sentences. The silences also serve to colour the vocal line (words being painted in music), and provide dramatic effect.

[PLAY PLAINSONG EXAMPLE] Track 3

Whatever these silences are, they are, apparently, not ‘nothingness’. Yet, there is some connection with nothingness in western perceptions of silence. Eastern ideas differ from this – for instance, the Japanese concept of “ma” (at its simplest, the space between events, or a sensory or sensual perceived space). In my culture, silences in everyday life can be considered negative, or threatening, particularly if shared with those we do not know very well. Intimate silences, between us and the people we love, can have other qualities of connection and separateness-within-togetherness. Silences are not only “somethingness”, but a lot of different kinds of “somethings”.

Silence and death

At this stage, it is appropriate to pause briefly to remember how *silence* has been defined. The scientific definition relates to what can occur in outer space, something that is not possible for humans to perceive. Experiments have shown that even if deprived of sound sources and in a sealed, silent environment, we become aware of sounds and sensations from inside our bodies. It would appear that sound (in the sense of our hearing being defined as the perception of vibration affecting our bodies) is an inescapable part of life. Even before we are born, our world is noisy; intrauterine life is certainly not silent - it is full of a great deal of acoustic stimulation (Piontelli, 1992, pp.34-38). From birth onwards, sound is all around us. It is an essential and unavoidable part of being alive. Even those who describe themselves as deaf are sensitive to the vibrations in the air that are registered as ‘sound’ by the hearing.

From the beginning, life itself is associated with sound; therefore, the potential for connections between silence and death are also with us mere weeks after conception. The link between death and nothingness is apparent in the notion that silence can be thought of negatively, for instance in the idea that silences can hold the unspeakable. Apart from in death, silence might be where we find the tension of something withheld, or something fearful, or something threatening. Van Camp, a psychotherapist, observed that this quality of negative association with silence is also apparent in the art form of music, defining musical silence as “the unrepresentable affect” and linking it to that which is deeply traumatic (Van Camp, 1999,

pp.267-8). Dictionary definitions of silence also refer to negative qualities; that is, silence as an *absence* of sound. In contrast, in the east the term silence has been linked with a sense of presence and accepted as something positive, with purpose and value. Despite these varying approaches to defining silence, there is a general belief world-wide that silence is immensely powerful, and it comes as no surprise that silences have a particular power within a musical work. And, as well as silence creating expectancy, tension and dramatic effect, there are the intimate silences.

Composers sometimes leave gaps between sounds, during quieter, more tender musical passages. These gaps in sound open up more intimate spaces in us, as in the next two examples. First, from a song about loss. The silences here slow the pace of the music and emphasise the words, and these words come out of silence, highlighting the quiet intensity held in the singer's voice.

[PLAY BERLIOZ SONG (end)] Track 5

In the second example, vulnerability is revealed through a different use of silences. Here, during the course of an opera, three people wish two young men safe passage as they set out to sea. The orchestra begins by playing an oscillating chord feature, like the gentle winds that push the sails, or the very waves on which the men travel. We will hear a kind of silence, where this orchestral support is withdrawn, and the voices are left almost alone, without the previous musical texture, perhaps reminding us of the vulnerability within both travellers and well-wishers. There are also brief silences in the transparency of changes of texture in the instrumental music, and in the interplay of voice and orchestra, heard either in the ongoing music, or within single lines.

[PLAY MOZART COSI FAN TUTTE] Track 6

So, silence frames various aspects of music. This begins in the space before the first musical sound begins, and ends with the space after the last musical sound has finished resonating. Silence frames each motif, theme or musical utterance, and longer silences can relate to form and structure. There are also relative silences, such as within texture changes, or in the un-heard silences in a single instrumental part. Silences interrupt the flow of sounds and create their own tensions. For instance, there is an inherent tension within what is unspoken, for instance when musical sound ceases and the momentum of the music is interrupted. This unexpected sound-absence disturbs the equilibrium of the listener in a profound manner, perhaps linked to the 'unrepresentable affect' that Van Camp wrote of. At such moments the listener is left with an awareness of aloneness (death) and an associated need for sound (life). Another element concerns the space offered to the lis-

tener within which they will search to hear the unspoken. This aspect of silence is no longer receptive, but rather demands an active response from the listener. There is an inherent movement within such a concept of silence. It is a movement from response to *reaction* (from the outer to the inner state) and then to *action* (the inner to the outer). As Rowell noted in the quotation I began with, silence is integral to music. Something of great significance exists in music's apparent 'nothingness'.

Silence, absence and presence

We can think of the creative act itself as coming from silence, inextricably linked with a state of un-knowingness, and a letting-go of conscious thought processes, in order that there is space and freedom for the music that is yet-to-become.

Surely, the most significant aspect of silences in therapy is the way in which the therapist listens and attunes to what is not sounded. This is not only listening to what is in the air between client and therapist, but what is within the therapist, and in their human response to the client. We all have our particular viewpoint or stance about this, yet, detailed references to our being-state within the *silence before the client plays* are almost non-existent in the literature. A notable exception De Backer's term *anticipating inner silence*, broadly defined as:

(read by Jaakko)

“...the silence before the first sound is heard. Each authentic musical play originates from this anticipated silence, which makes it possible for one to come into resonance with oneself, and in a music therapeutic context, with the other. One can describe this as the musical presence of the inaudible sound, a sound that is not only inaudible, but also completely unknown and unimaginable.”²

De Backer also describes how the therapist must, in the same way, listen at the moment of making music with the client, allowing themselves to be “surprised”, “overtaken” and guided by it. This silence is *inaudible sound without an owner*, perceived by the therapist when in this receiving state. It carries an anticipation of the unknown, within the therapist's necessary inner space – openness to which must be discovered or created.

2. De Backer, personal communication (PhD in progress)

I believe that this anticipating, inner silence is particular to the work of a music therapist, because it requires both therapeutic and musical listening, and a combination of both. It is a many-layered listening, stemming from an underlying state of openness in the therapist.

Here is an example of such a silence, from the beginning of a music therapy improvisation.

You will hear two musicians: the client, a young boy with a traumatic history, plays little finger bells; the therapist, the piano. Notes from the therapist stated:

“He chooses a new instrument: the small finger cymbals. The beginning was surprising: he sits down quietly beside me at the piano and a silence appears. Immediately, I come into resonance with him and myself. During this resonance, I almost “get caught” by something that I did not expect at all, like an atmosphere that comes over me and inspires me. Not knowing what inspires or animates me, spontaneously I slow down my pace. I realise that I enter into a kind of melancholy state. I surprised to notice how time is being stretched and how I am drawn to a particular musical motif. It is not the music that follows me, but it is I that follow the music. I am surprised by something that pops up in the relationship with him, and, immediately, he reacts.”³

While you listen to the example, notice the quality of the tension in these silences. They are fragile, yet there is an intangible underlying security, as if something is safely holding this client’s delicate vulnerability. The lengths of the silences differ, sometimes obviously, sometimes more subtly. The quality of the silences is not static, it changes, and the pacing differs from silence to silence. There is a sense of time suspended, where a moment could become simultaneously an instant in time as well as the beginning of a link to something past, of a possible continuity. At times, the silence feels unbearable, yet somehow potentially manageable. These are silences containing paradox – silences perhaps on the threshold of absence and presence. (You might want to close your eyes as you listen.)

[PLAY OPENING OF MUSIC THERAPY (STILTE) EXAMPLE] Track 7

Given this client’s traumatic history, what is most striking is the way that, from the beginning, these musical silences (owned by therapist, and by client and therapist together) have a sense of continuity. In this case, the silences can begin to hold something traumatic, rather than *become* something traumatic.

3. De Backer (in progress; personal communication)

Silence as an active agent of change

Silences are not only active components of music, but they are also not static within themselves. They are not in one particular state throughout – just as the movement of dynamic form is heard in the sounds, so it is present in silence. In the music therapy room, as heard in the clinical example, process in silence can open up new spaces, and hold different experiences of time. In work with traumatic conditions, a slowing of overall pace can allow the potential space for something else to become, and rather than repetition of the old, there is a possibility of something new.

The second clinical example is from the end of the third session with a 6 year-old autistic boy, “Brian”. The therapist described their responses to Brian’s music in the following way:

“Brian played, moved and vocalised in short bursts, flitting between instruments and different parts of the room. There was an overwhelming quality of his music ‘flying off’ towards something else; almost before he had played, he moved away. There was nothing continuous in his music, apart from the repetition of returning to the instruments from time to time. I was careful how I responded to what he offered. To match his fragmented playing too closely would be intrusive for him and only add to the anxiety level in the room, but not to acknowledge his music would leave him abandoned. I made an open, non-threatening musical atmosphere, improvising predictable and slower-moving music, with predictable, repeated chords that sometimes changed in reflection of Brian’s short bursts of playing. A sense of continuity was offered in a simple melodic line. Gradually, a waltz emerged, its key of A minor both matching the tuned percussion tones and - more importantly – providing a serious and at times more sad, poignant or wistful mood. This matched Brian’s underlying mood and also my responses to how we were connecting musically. The waltz pacing was flexible, often pausing at the ends of phrases, or when Brian was about to begin or finish playing. The idiom was selected because of its third beat, which allowed a “stretching” of the music with flexibility, in order to help shape his spontaneous responses. Gradually, he became able to sustain his music for increasingly longer periods, revealing a less heightened state of anxiety. He settled for a longer period of time at the metallophone, his music at times tentative, anxious and tenuous. The intensity of his playing varied and in a way I could hear how Brian ‘was’ from moment to moment musically. I shaped Brian’s responses, at different times waiting, holding back, pushing forward. The aim was to provide some sense of continuity within which his fragmented responses could sit. After almost ten minutes, the music slowly drew to a close. There was a long silence, during which Brian gently placed his beaters onto the instrument. At the end of the silence he sighed and breathed out.”

[PLAY MUSIC THERAPY (BRIAN) EXAMPLE] Track 8

The intensity of this final silence meant that it could not be broken until Brian breathed again – it was, simply, his silence, within which time was suspended. It was a silence that held the therapist's presence, and also some of Brian's, in a situation where he had found it very difficult to remain. It marked a passage of time where there was a definite sharing of time and space between Brian and his therapist, a space that he was just able to hold onto. There was also something both delicate and precious about this silence; it marked presence in the face of overwhelming absence. The silence also offered a space where it might be possible to assimilate and begin to process something of what had occurred within the musical sounds. It was a silence that was highly significant, because it was both within the therapist and also between therapist and child. In terms of Brian's therapy it also spoke silently of the future progress of the therapy (i.e. the connecting to another person and the growing of a relationship). Perhaps the nature of this silent space in the therapist, and between the therapist and Brian, was delicate and significant because it was also beginning to 'be' in Brian, identifiably so in his need to hold his breath as he held onto the possible sensations of connectedness.

These two clinical examples show that in common with other disciplines, music therapists certainly experience and work with absences of musical sounds. Yet, very few have written about silence in any depth, tending to deal with the topic as part of a larger picture.

Claire Flower is one of a very small group who has considered the phenomenon in detail. In a conference paper, Flower offered a clinician's view of the significance of silence, summarising three different aspects:

(read by Jaakko)

Firstly, for the client the space between the notes and phrases may relate to and enable experiences of identity and separateness. They can hear not only their sounds, but also the responses of the therapist, bringing an awareness of self and other. Secondly, space [without actively making sound] allows the therapist room to think about, listen to and digest what it is that the client is doing. Thirdly, when both therapist and client are able to tolerate and create silent spaces, something in addition may be grasped about the nature of the connection between them. (Flower, 2001)

Flower has examined a many-layered listening, including awareness of the communicative potential between each sound, what is contained in a silence, and listening to and *feeling* the quality of connection that can exist between those sharing and negotiating the silence. In undertaking these kinds of listening there can be a heightened sense of awareness for both therapist and client. This is awareness of

both self-with-an-other, and self-alone, and it utilises silence as something capable of incorporating both presence and absence.

An exception to the lack of depth research in this area is the concept of the *anticipating inner silence* discussed earlier. Other types of clinical silence are also discussed by De Backer, including the therapist's silence while the client is active, and discussion of therapeutic transference and counter-transference issues. Fragmented silences are considered, where there is an inability to sustain musical play and a breaking of the musical connection with the therapist as a result of an underlying, deep, fundamental trauma. It is in this area in particular that silences have the strongest clinical value, although, of course, all silences have meaning, whether apparent or hidden.

Silence as a hidden music

In thinking about and listening to silence, the idea that this could be a *hidden music* is suggestive of something withheld, something denied, something behind or beyond the obvious. What is brought to any music therapy space is a mixture of the obvious, the apparent and the hidden⁴. Within music's paradoxes can be held a fit with the ambivalence of the client/patient and of the paradoxes within the human condition. This reminds us of some aspects of silences in the therapy room. Silences that once were considered the property of clients' defensive structures are now viewed with more complexity and subtlety, in that silences in therapy signify process rather than outcome. Both in the more recent therapy literature and in my experience of dialogue between music therapists, the role, function and place of silence is being re-defined.

Silences can be heard and felt as presences, as absences, and as thresholds between the two. They mark the boundary of the therapy space. They might become related to the overall shape or form of the session, or exist only as the defining characteristic for the time that therapist and client spend together. For the clinician, the silence at the beginning of a session can be a space for waiting-without-expectation, but with an openness to what might come - whatever it might be -, where the therapist can take notice of feeling responses to the client and open themselves to the potential for a shared space. Winnicott wrote of the duality of such a space, where both separateness and togetherness could occur, giving the image of string that both sep-

4. See De Backer, Van Camp (1999: 12)

arated and joined therapist and client (Winnicott, 1971; 1982). Rather than the silence being a lack of something between therapist and client, it is already beginning to define the presence of both.

I recently asked a range of music therapist colleagues for their thoughts about silence, and amongst the responses were the following points:

On a silence after a clinical improvisation in individual music therapy:

- “It was hard to describe when the last note died – the silence enabled the note to stay, as well as go. It felt profound, and it belonged to the client, and the experience they had just had.”
- “This silence and space was not time limited.”
- “The silence was an affirmation of the relationship.”

On silence in music therapy

- “People tend to find silence difficult to be with – the ‘spoken’ can be easier than the ‘unspoken’.”
- “We can be focused so much on how we are responding musically to our client. If we were to listen to the whole shape as a musical work – that is, that the client’s musical and non-musical behaviour is all creating a musical whole – then we would treat the existence of silence differently.”
- “In silences in music therapy the musician is already present in the music before the music sounds.”

This demonstrates that we all indeed know about silence in our work. But, we do well to actively remember the subtlety, power and intricacy of silent states.

My next example will end this presentation. The topic of silence, like many other research subject, raises many more questions than answers. During this presentation, I hope that you have made your own discoveries of questions, old and new. This final example is of a trumpet questioner, asking and asking, and being met with woodwind answerers who seem to be in some conflict with each other. Yet, like silence, the underlying presence of the strings seems to provide affirmation of the question and the questioner and what responses occur. It seems fitting to allow this music to frame my presentation, along with the silence afterwards.

[PLAY IVES UNANSWERED QUESTION] Track 9⁵

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5. Charles Ives writes: The part of the flute quartet may be taken by two flutes, upper staff, oboe and clarinet, lower staff. The trumpet part may be played by an English horn, an oboe or clarinet, if not playing in "The Answers." The string quartet or string orchestra (con sordini [with mutes]), if possible, should be "off stage", or away from the trumpet and flutes. ... The strings play ppp [pianissimo – very softly] throughout with no change in tempo. They are to represent "The Silences of the Druids – Who Know, See, and Hear Nothing." The trumpet intones "The Perennial Question of Existence", and states it in the same tone of voice each time. But the hunt for "The Invisible Answer" undertaken by the flutes and other human beings, becomes gradually more active, faster, and louder through an animando [more animated] to a con fuoco [with fire]. This part need not be played in the exact time position indicated. It is played in somewhat of an impromptu way; if there be no conductor, one of the flute players may direct their playing. "The Fighting Answerers", as the time goes on, and after a "secret conference", seem to realize a futility, and begin to mock "The Question" – the strife is over for the moment. After they disappear, "The Question" is asked for the last time, and "The Silences" are heard beyond in "Undisturbed Solitude."

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*Making friends in music:
including children with
autism in an interactive
play setting*

Kern, Petra

Keynote 3 on Thursday morning, June,
17th 2004, 9:45-10:30 am

Abstract

Young children with Autism Spectrum Disorder frequently experience difficulties in making friends. Specific characteristics of autism, such as focusing on people in the environment, comprehending and using verbal and nonverbal language, playing meaningfully with toys and interacting with peers, may interfere with the ability to

achieve group membership and to form friendships. The social ecology of interactive play settings may influence these children's social engagement, learning and development positively. Thus, children with autism are increasingly being included in community-based interactive play settings, receiving their therapeutic services in the context of ongoing class activities and routines. However, environmental arrangements and child-focused interventions emphasizing the children's strength and needs are necessary for successful inclusion.

This paper describes a cumulative case study design investigating the effectiveness of embedded music therapy interventions designed for the inclusion of young children with Autism Spectrum Disorder in an inclusive childcare program. Each of the three interventions addressed a key difficulty the targeted children faced during classroom activities and routines. These corresponded to (a) the morning greeting routine; (b) multiple-step tasks within classroom routines; and (c) peer interactions on the childcare playground. To increase the target children's independent performance, seven individually tailored songs and two pre-composed songs were used and an outdoor music center was added to the childcare playground. Children's individual educational goals, coupled with the strategies commonly used with children with autism, were taken into consideration in the design of the interventions and song development. Collaborative consultation, including staff development activities, occurred prior to and during each intervention. The effects of these interventions were evaluated using single-case experimental designs.

The results indicated positive effects on all target children's performance within the childcare routine: In eight of nine cases, the songs produced desirable outcomes. The musical playground environment facilitated the involvement of children with autism with peers. The music therapy collaborative consultative approach enabled teachers to implement interventions successfully in ongoing childcare routines. Peer-mediated strategies increased peer interactions and meaningful play on the playground and laid the foundation for forming friendships.

Contemporary models of music therapy service delivery in inclusive childcare settings, particularly implications of the collaborative consultative approach, will be discussed, as will the need for future research and directions.

What we know about inclusion...

The socio-cultural environment is an integral force in a child's learning and development (Berk & Winsler, 2002; DEC, 2000; Piaget, 1951; Stern, 1985; Vygotsky,

1978). Full inclusion of children with special needs in their natural environments – such as community-based interactive play settings – has been supported on ethical, legal, and educational grounds (Wilson, 2002; Wolery & Wilbers, 1994). For young children with Autism Spectrum Disorder (ASD), whose social interactions and relationships, language and communication, and behaviors are significantly affected, early education and treatment can greatly enhance the child's ability to participate meaningfully in family and community life and to play a vital role in society (American Psychiatric Association, 2000; Autism Society of America, n.d.; TEACCH, 1999; National Research Council, 2001; Wolery et al., 2001). Early experiments on inclusion give young children with ASD the opportunity to imitate peer models, interact and communicate with competent partners, provide realistic learning experiences in a natural environment, establish group membership, and lay the foundation for forming friendships with typically developing peers. Typically developing peers involved in such experiments, for their part, may improve their social skills and attitudes toward individuals with disabilities (Buysse, 1993; Jellison, 1985; Kluth, 2003; Peck, Odom, & Bricker, 1993; Wolery & Wilbers, 1994).

This knowledge has led to a trend toward more widespread placement of young children with ASD in community-based preschools or childcare programs (Dawson & Osterling, 1997; Handleman & Harris, 2001; National Research Council, 2001). But to ensure successful inclusion, the application of child-focused interventions emphasizing the child's strengths and needs as well as environmental arrangements are imperative (Danko & Buysee, 2002; Sandall, McLean, & Smith., 2000; Schwarz, 2002; Wolery & Wilbers, 1994).

Service delivery in interactive play settings

Several educational and therapeutic interventions and strategies have been suggested for effectively including and educating children with autism (Koegel & Koegel, 1995; National Research Council, 2001). Toward this end, the Division of Early Childhood (DEC) (Sandall, McLean, & Smith, 2000), as well as the Committee on Educational Interventions for Children with Autism (National Research Council, 2001), recommend that interventions be embedded in ongoing classroom routines. The rationale for inclusive service delivery is manifold (McWilliam, 1996; Wesley, 2004; Wolery & Wilbers, 1994): (a) to minimize stigma and isolation by having the child remain in class with her/his peers; (b) to capitalize on the child's naturally occurring learning opportunities by providing support in context; (c) to increase the number of experiences that promote learning by addressing daily problems whenever they occur; (d) to promote social competence by keeping the

child involved in activities with classroom peers; (e) to increase generalization by practicing the skills needed in the place they are needed; and (f) to ensure consistency by having all the adults working with a child be aware of the rationale for providing treatment and the implication of the intervention.

Contemporary service delivery in high-quality center-based childcare programs is based on an integrated therapy model – meaning specialized therapies are delivered in the context of the child’s naturally occurring environments, routines, and activities (Dunst et al., 2001; Sandall, McLean, & Smith, 2000; McWilliam, 1996, 2000a, 2000b; Wesley, 2004). To ensure normalization, continuity, maintenance, and generalization, therapists work with the individual child or a group of children within the ongoing classroom routines, or as consultants to the classroom staff and families to embed therapeutic goals (National Research Council, 2001; McWilliam, 1996). Table 1 illustrates the continuum of six models of service delivery within inclusive childcare setting from a music therapy perspective (adapted by the author from McWilliam, 1995).

Occupational therapists (Dunn, 1996; Sandler, 1997), speech/language pathologists (Wilcox & Shannon, 1996), physical therapists (Rainforth & Roberts, 1996; Sandler, 1997), and special educators (Garfinkel & Schwartz, 2002; Venn et al., 1993; Wolery et al., 2002) have evaluated and successfully applied the integrated therapy model in inclusive childcare settings. But this approach has not been widely applied, nor have music therapists yet evaluated it.

Music therapy — A suitable treatment option?

Music therapy has a long tradition of serving young children with special needs, especially those with autism (Alvin & Warwick, 1991; Nordoff & Robbins, 1977). Studies on interest in music and relative strength of musical abilities in children with autism (Applebaum et al., 1979; Blackstock, 1978; Thaut, 1987, 1988), and anecdotal reports on the quality of music as a means of nonverbal communication, social contact, and self-expression (Alvin & Warwick, 1991; Nelson, 1984; Nordoff & Robbins, 1968; Schuhmacher, 1994), suggest that music therapy is a suitable treatment option for individuals with ASD. Music therapy interventions address the challenges associated with autism in an intentional and developmentally appropriate manner and might be effective in facilitating development of core skills and personal growth. Key strategies applied to educating children with autism – such as individualization, structure and predictability, and emphasis on the child’s strengths and individual needs – are incorporated in music therapy treatments or are part of

the nature of music itself (AMTA, 2002). Music therapy also strongly supports and facilitates inclusion of children with special needs in various educational settings (Wilson, 2002). That said, the effectiveness of music therapy interventions for the inclusion and improvement of core skills in young children with autism enrolled in inclusive preschool settings is documented by few music therapists (Furman, 2001, 2002; Humpal & Wolf, 2003; Snell, 2002), and controlled studies of any kind are missing altogether.

Although music therapy services can either be provided directly to clients or through consultation with professionals and others directly involved with the client (AMTA 2003), only 13% of the music therapists in the U.S. provide consultative services in educational settings (Smith & Harrison, 1999). Some attention has been paid to embedded treatments and the collaborative and consultative models of music therapy service delivery as effective strategies for including students with special needs within public school settings (Furman, 2002; Humpal, 2002; Johnson, 2002; Snell, 2002). But the literature that has been published – program descriptions, guidelines, strategies, and outlines of the benefits of this model of service delivery – is not the result of formal scholarly research investigations but rather of formative best practices research. Additionally, no information is currently available to describe whether or not integrated models of service delivery, especially collaborative and consultative strategies, are common clinical practice in music therapy for serving young children with special needs in interactive play settings.

TABLE 1. Continuum of six models of music therapy service delivery in inclusive childcare settings.

| Model | Individual Pull-Out | Small Group Pull-Out | One-to-One in Classroom | Group Activity | Individual During Routines | Consultation |
|----------|--|--|---|---|--|----------------------------|
| Location | In music therapy room or other location apart from the classroom | In music therapy room or other location apart from the classroom | In classroom, often apart from other children | Classroom/ playground, small or large group | Classroom/ playground, wherever the child is | In or out of the classroom |

TABLE 1. Continuum of six models of music therapy service delivery in inclusive childcare settings.

| | Directly on the child's therapeutic objectives | Directly on child(ren) with special needs' therapeutic objectives | Directly on the child's therapeutic objectives | On all children in group and on social skills; emphasizes focal child's needs | Directly, but not exclusively on the focal child | MT works primarily with the teacher; MT and teachers collaborate on the best approach the teaching staff should use in order to meet the child's identified goals |
|----------------------|--|---|--|---|--|---|
| Therapy Focus | | | | | | |
| | Not present | 1-6 peers present | Peers present, but not involved | Some children in group have special needs, some not | Peers usually present | Present if occurring in childcare setting |
| Peers | | | | | | |

TABLE 1. Continuum of six models of music therapy service delivery in inclusive childcare settings.

| | Provide individual music therapy; exchange information before and after therapy with teacher | Provide group music therapy; exchange information before and after therapy with teachers | Provide individual music therapy in child's classroom; take child to an area and work on child's therapeutic objectives or conduct assessment; teacher prevents interruptions of therapy; provide and receive information before and after therapy to teacher | Provide group music therapy in the classroom/ playground with focus on a particular child; share professional knowledge and involve teacher in planning and implementation; take lead and co-lead | Provide individual therapy within the child's ongoing classroom/ playground routine; share professional knowledge with teacher and train teacher to use music therapy strategies; exchange information with teacher before and after routine | From expert consultation where the MT provides guidance, information, and training on the use of therapeutic techniques, to "collaborative consultation," where the MT (consultant) and teacher engage equally in defining the problem; identifying the goals of intervention; planning the intervention; and engaging in follow-ups |
|--------------------------------------|--|--|---|---|--|--|
| Music Therapist's (MT's) Role | MT comes to classroom, takes the child to the music therapy room to work on the child's emotional expression through music and then returns the child to the class at the end of the session | MT takes four children to the music therapy room to work on social skills such as turn taking and then returns them to their classroom | MT goes to the classroom, takes the child to the circle time area, places instruments she has brought with her on the floor, and assess the child's non-verbal communication skills | MT goes to the classroom during circle time and has the whole class participate in social interaction songs and musical activities focusing on one particular child's peer interaction | MT goes to the playground and prompts the child to play the drums in the Music Hut, gives model for meaningful engagement and activities. Makes sure that teacher can watch and hear | MT observes children on the playground, then talks to the teacher while the teacher supervises the children, asking how things are going with a certain child and what she thinks they should do about any challenging behaviors |
| Example | | | | | | |

Most segregated to most integrated model

Adapted by the author from McWilliam, R.A. (1995). Integration of therapy and consultative special education: A continuum in early intervention. *Infants and Young Children*, 7 (4), 29-38.

The research journey

The purpose of the following series of studies was to understand if individually designed music therapy interventions will increase the performance of seven young children with ASD during challenging routines in an inclusive childcare program and to learn if teachers can embed the interventions in the ongoing classroom routine. The interventions addressed difficulties the targeted children faced during (a) the morning greeting routine, (b) multiple-step tasks within classroom routines, and (c) peer interactions on the childcare playground.

The project was conducted at the inclusive Family and Childcare program of the Frank Porter Graham (FPG) Child Development Institute, which is affiliated with the University of North Carolina at Chapel Hill, USA (FPG Child Development Institute, 2002; 2004). The Family and Childcare program enrolled about 80 children from six weeks of age to five years old. Children with and without disabilities attended the same classroom, where the philosophy followed developmentally appropriate guidelines (Bredekamp & Copple, 2002). Of the 30% of the children with various disabilities, 11 were diagnosed with ASD by external agencies using the Psychoeducational Profile-Revised (PEP-R) (Schopler et al., 1990), Autism Diagnostic Observation Schedule (ADOS) (Lord et al., 1999), Vineland Adaptive Behavior Scales (Sparrow et al., 1984), Childhood Autism Rating Scale (CARS) (Schopler, Reichler, & Renner 1988), clinical observation, and parent interviews. Classroom peers included both male and females from different ethnic groups and were ages two to five. All experiments were undertaken in the childcare programs' inclusive classrooms or playground using the integrated therapy approach.

Diverse cultures' use of songs to accompany daily life activities and to heal (Hart, 1990; Morgan, 1994; Silver, n.d.) as well as the wide range of professionals using songs with preschoolers to address academic, social, language and communication, motor skills and to express emotions (e.g., Enoch, 2002; Furman, 2001; Humpal, 1998), led to the design of song interventions. At the FPG childcare program, well-known children songs were part of the curriculum and practiced during group activities. Using individualized songs with young children with ASD to increase their

performance during challenging classroom routines seemed to be a promising and manageable approach to be implemented by teachers into the ongoing classroom activities and routines. In all experiments, a unique song, matching the target child's temperament and demands of the identified difficulties, was written by the author in collaboration with the classroom teachers. Specific goals, strategies, and procedures were individualized for each target child, and predictable routines, structured teaching, and visual cues, as generally used with children with ASD, were taken into consideration in the interventions' design. The playground used in this study has been modified by adding an outdoor music center (Music Hut) so as to structure and create a musical environment that enhances the social and play experiences of young children with autism, together with their peers, in outdoor play.

The music therapy interventions were designed and implemented by using a music therapy collaborative consultative model of service delivery. Staff development activities on the use of music therapy techniques to implement the intervention were provided prior to each experiment. In addition to the teacher-mediated interventions, peer-mediated strategies were applied to increase peer interactions on the childcare playground (McGee, Morrier, & Daly, 2001). Parents and caregivers were fully included in the morning greeting routine intervention and supported through frequent communication prior to, during, and after the experiments. Classroom peers directly participated voluntarily in Experiment I and III. Caregivers participated in Experiment I; classroom teachers participated in all three experiments.

The effects of the following music therapy interventions were evaluated by using single-case experimental designs. This research methodology provides professionals in early intervention a controlled experimental approach to the investigation of a single child under different circumstances, as well as the flexibility to adapt the intervention to the child's needs and the particular treatment approach. Experimental control is achieved within the child, meaning that each child serves as his or her own control by comparing the child's performance across two or more conditions over time (Alberto & Troutman, 1995; Aldridge, 1996; Barlow & Hayes, 1984; Hanser, 1995; Holcombe, Wolery, & Gast, 1994; Kazdin, 1982; Tawney & Gast, 1984; Wolery, Bailey, & Sugai, 1988).

Experiment I: Morning Greeting Routine

INTRODUCTION

For many children – those with and without disabilities alike – one of the most crucial transitions is that from home to preschool (Alger, 1984). Making transitions is particularly difficult for children with autism. The preferences for sameness and sensitivity to changes, as well as the lack of understanding of symbolic gestures (such as waving for greeting or good-bye), are among the defining characteristics of autism (Dawson & Osterling, 1997; Mesibov, Adams, & Klingler, 1997). A number of strategies, including the use of songs have arisen to support children with autism in making successful transitions. “Hello” and “good-bye” songs are often used in music therapy to establish a predictable routine and to structure the session, to welcome and get in contact with the individual or group, to give the individual undivided attention, and to establish awareness of where persons are and what comes next (Bailey, 1984; Hughes et al., 1990; Krout, 1987; Loewy, 1995). To initiate friendships among children with and without disabilities, Cooper and McEnvoy (1996) also suggest greetings that consist of a pat on the back, a brief game, or a greeting song.

METHOD

Participants. Participants in this study were Phillip and Ben, two three-year old children diagnosed with ASD (n=2) who exhibit difficulties with the classroom’s morning greeting routine (see Case Vignette: Ben), and their peers with and without special needs (n=13), classroom teachers (n=5), and the target children’s respective caregivers (n=2). The aim of the intervention was to increase the independent performance of target children during the morning greeting routine by way of unique greeting songs implemented by classroom teachers and the inclusion of peers and caregivers.

Setting. The experiment occurred in the subjects’ inclusive childcare classroom. The classroom curriculum allowed free play during the morning arrival time. Children engaged in different play areas by themselves or with each other.

Materials. A unique greeting song was composed for each subject, following the demands of the desired five-step morning greeting routine as well as a “Hello” picture symbol, which was employed by the subjects to greet classroom teachers and peers.

Experimental Design. Using an A-B-A-B withdrawal design for Phillip, and a modified version of this design (A-B-C-A-C withdrawal design) for Ben, the effectiveness of the song interventions was evaluated. The baseline (Conditions A) followed the steps of the morning greeting routine. The song intervention (Condition B) followed the steps of the morning greeting routine by using each unique greeting song. The song intervention (Condition B) was modified by eliminating the “good-bye” section of the routine (Condition C).

Procedure. During baseline, teachers greeted the subject and followed the identified five steps of the greeting routine as soon as the target child entered the classroom at morning arrival. During song intervention, the song, whose musical format and lyrics matched each of the five steps of the greeting routine, was sung by teachers, parent/caregiver, and classroom peers (see Case Vignette: Ben).

Measurements. Categories of behaviors were coded through direct observation using an event recording system.

Reliability. Reliability checks were carried out within each condition and for each child. The overall interobserver agreement for Experiment I was 94%.

RESULTS

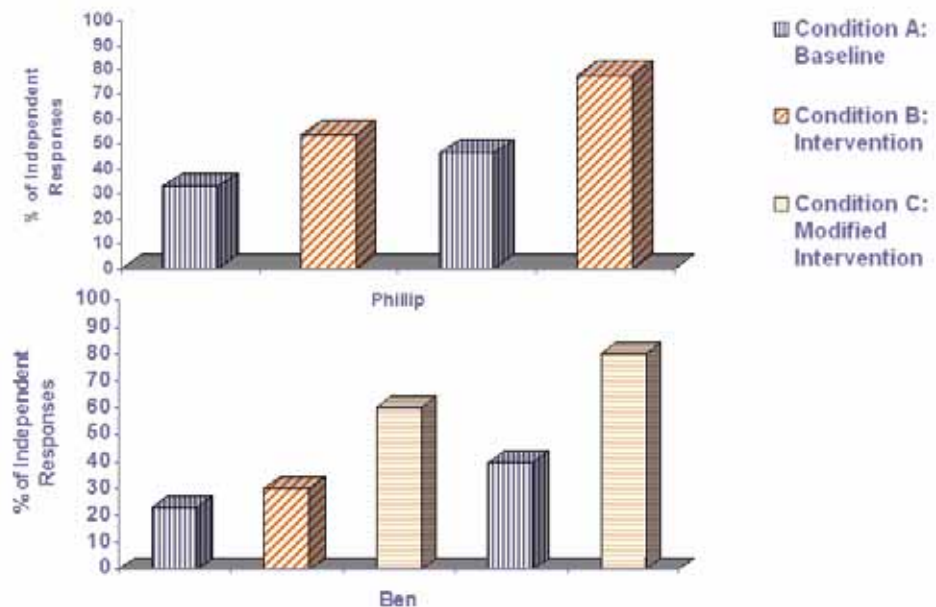
Phillip. The results of this investigation indicate that during baseline (Condition A) Phillip had a low level of independent performance (\underline{M} =33.3%). With the introduction of the song intervention (Condition B), he steadily became more independent (\underline{M} =54%). The withdrawal of the song intervention immediately decreased his performance (\underline{M} =46.7%), and re-introducing the song increased his independence once again, this time on an even higher level (\underline{M} =77.8%).

Ben. The results demonstrate that during baseline (Condition A), Ben exhibited a low level of independent performance (\underline{M} =23.3%). The initial implementation of the song intervention (Condition B) did not change his performance significantly (\underline{M} =30%), while the modified song intervention (Condition C) increased Ben's independent actions immediately (\underline{M} =60%). After withdrawing the song, Ben's independent behavior decreased (\underline{M} =40%).

Re-introducing the modified song intervention (Condition C) produced a high level of independent performance (\underline{M} =80%). As evaluated in Ben, the song intervention changed the classmates' greeting behavior toward the target child and increased peer interaction. As for the positive outcomes of the interventions, it is apparent

that classroom teachers successfully implement interventions based on music therapy principles into the ongoing classroom routine.

FIGURE 1. Mean (M%) of independent responses for Phillip and Ben during the morning greeting routine in each condition of the study.



CASE VIGNETTE: BEN

Since 10 months, three-year-old Ben attended a community-based childcare program five mornings a week. He was diagnosed with ASD and had difficulty transitioning from home to school. Each morning when his nanny brought him to school, Ben held on to her, cried or screamed and ignored any efforts of his teachers to welcome him. His nanny reported feeling “bad” about leaving Ben while he was upset, teachers “dreaded” the arrival of the child, saying things like “it’s fine once he’s here, but just getting him here is hard,” and peers did not take notice of him and went about their play. His Mom and teacher hoped that he would learn to enter the classroom happily and independently, greet his peers during morning arrival time

by communicating “hello” in some way, wave “good-bye,” and engage in meaningful play.

Both Ben’s Mom and his teacher noticed that he was interested in song activities, playing musical instruments, and listening to soft and mellow music. During an interdisciplinary team meeting, Ben’s classroom teacher asked about the efficacy of music therapy interventions for Ben’s challenging morning transition. The music therapist, familiar with the child, suggested using a greeting song incorporating the morning greeting routine in use by Ben’s classmate. After the team agreed on five specific steps for the greeting routine and identified additional individual education goals, the music therapist composed in close collaboration with the classroom teachers a unique song tailored to the child’s challenges, personality, and strengths. Together they worked out how the song intervention will fit into the existing morning routine. The music therapist provided musical training to the teachers and caregiver and modeled how to include Ben and his peers in the morning greeting routine.

When the adults felt comfortable with using the song and Ben’s new morning greeting procedure, the teachers implemented the intervention in the ongoing classroom routine. As soon as Ben entered the classroom, his nanny and classroom teachers sang each step of the greeting song to Ben. Ben entered the classroom and looked for a peer to greet by exchange a “hello” picture symbol. His teachers first prompted him to follow each step of the routine and then gradually withdrew their support. Peers began to cluster around him each morning, singing the song and wishing him a “good morning.” However, the “good-bye” part was still troublesome to him and triggered undesirable behaviors such as biting and scratching. After consulting with the music therapist, the teacher and caregiver decided that it was too hard for Ben to understand both concepts: greeting and saying good-bye. Therefore they eliminated the good-bye part of the greeting routine and Ben’s caregiver left after he entered the classroom smoothly.

On many days Ben now enters the classroom with a smile on his face, joyfully jumps up and down, and vocalizes or names a peer to greet. The song intervention evokes a positive view and interest of peers toward Ben as evident in remarks such as “He doesn’t cry anymore,” or “He did a great job.” Peer interaction frequently continues when Ben plays a hand drum that is offered to him as a toy to play with for the last step of the routine. Furthermore, teachers’ and the caregiver’s stress level has been reduced due to Ben’s smooth transition during arrival time. Ben’s Mom is very pleased and satisfied seeing her son’s positive development and uses other songs to teach him skills at home.

Experiment II - Multiple Step Task Study

INTRODUCTION

The childcare day is not only filled with transitions, but also with many routines, such as hand washing, toileting, and cleaning up, which are repeated on a daily time schedule. These routines require children to follow a sequence of steps that typically cause significant difficulty for children with autism (Boswell & Gray, 2003; Williams, 1996). The inability to understand the demands of this classroom routine might cause frustration and confusion, expressed in challenging behaviors. In order to function independently in daily life and achieve group membership, children must learn to understand, remember, and perform the sequence of these tasks.

METHOD

Participants. A three-year old-boy, Andy, diagnosed with ASD ($n=1$), who had difficulties managing the sequences required for the multiple-step tasks (i.e., hand washing, toileting, and cleaning up independently) was the subject of this study along with his classroom teacher Clara ($n=1$). The intention of this investigation was to evaluate the effectiveness of songs embedded by the classroom teacher as structural prompts in increasing the independent performance of the target child during these classroom routines and to evaluate whether the musical presentation or the verbal presentation of the sequencing was more effective.

Setting. The experiment occurred in Andy's inclusive childcare classroom. Hand washing and toileting occurred on scheduled times throughout the day and whenever necessary. The classroom was divided in different play areas and contained corresponding toys and materials (Cryer, Harms, Riley, 2003). To cue the children to finish their play activity and transition to circle time, a song for cleaning up toys and materials was used.

Materials. For hand washing the teachers used the already familiar tune "Row your boat" (American Traditional) and expanded the lyrics by including seven steps of the hand washing procedure. For toilet training, a unique song was written, conveying the demands of the multiple steps for the subject's toilet training. The pre-composed song "Clean-up!" by Barney & Friends (Barney's Favorites Vol. 1, 1992) was used for cleaning-up toys and material after play activities. The teacher used transition objects (i.e., the toy in use) to cue the subject to engage in each multiple step task.

Experimental Design. Using an alternating treatment design replicated across these three tasks, the effectiveness of the song intervention (Condition A) versus lyric intervention (Condition B) was compared.

Procedure. In the song procedure (Condition A), each particular song for the three selected multiple-step tasks was sung to Andy by the classroom teacher (see Case Vignette: Andy). In the lyric procedure (Condition B), each step of the routine was spoken twice.

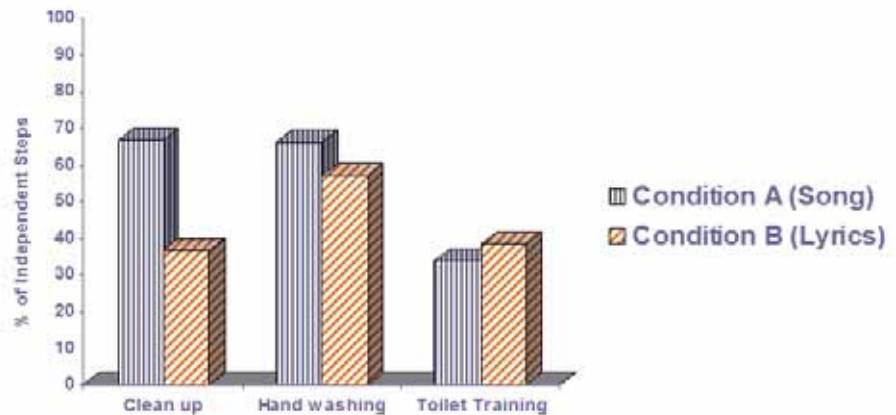
Measurements. Six categories of behaviors for each multiple-step task were coded through direct observation using event recording.

Reliability. Reliability checks were carried out on an average of 44.7% of total observations within each phase and for each multiple step task. The overall interobserver agreement was 96% of the trials.

RESULTS

Results of this study indicate that the implementation of either form of the intervention (song intervention/lyric intervention) was successful in increasing the target child's independent performance for each multiple-step task. However, the song intervention was more effective than the lyric intervention for the hand washing (song intervention \underline{M} =66% versus lyric intervention \underline{M} =57.1%) and cleaning-up procedures (song intervention \underline{M} =66.6% versus lyric intervention \underline{M} =36.7%), whereas for toileting the lyric intervention (\underline{M} =38.2%) was slightly more effective than the song intervention (\underline{M} =32%). As for the child's positive learning progress, the teacher embeds both forms of the presented sequencing in the ongoing classroom routines effectively.

FIGURE 2. Mean (M%) of Andy's independent steps during the clean up, hand washing, and toileting procedure in each condition of the study.



CASE VIGNETTE: ANDY

Andy was a 3-year old boy with ASD enrolled in an inclusive childcare program. His favorite activities were to identify letters and numbers, listen, dance, and sing to music. Clara, his classroom teacher, said: “Andy really responds well to music. He makes eye contact with me as soon as I start a melody. Singing songs with him during major transitions in the classroom helps him to understand what to do next.” However, Andy tended to have difficulties with managing the required steps of classroom routines such as cleaning up his toys after free play. Cleaning up at different times throughout the childcare day was a readily familiar routine for his classmates. Clara found it important to teach children to clean up because it keeps the classroom organized and functional, it signals the transition to the next activity, it communicates concepts of personal responsibility, and it promotes social skills such as helping skills.

Each child is expected to put toys back in the designated play area independently. To make the cleaning-up procedure a more fun activity for her class, she and the children would sing “Clean up” from Barney & Friends while putting toys in the designated area. Clara noticed that Andy stiffened his legs and body, flapped his arms, whined, tried to escape, and avoided cleaning up if she prompted him with

words to engage in cleaning up. But when she sang the cleaning-up song to him in the same situation, he started to clean up his toys as his classmates did.

Experiment III - Playground Interaction Study

INTRODUCTION

During the childcare day, children spend large blocks of time in outdoor play. The large undefined space, unstructured playtime, and play styles on the playground are highly challenging for children with ASD as measured by the ability to engage in meaningful play and interact with peers. The severe delay in understanding social relationships and communication among children with autism often results in a lack of peer interaction and forming friendships (Danko & Buysse, 2002; Quill, 2001). To ensure that time spent on childcare playgrounds promotes the development of children with ASD, predictable play routines and different play activities that support these children's interests and strengths need to be identified and established.

METHOD

Participants. This investigation involved four boys, ages three to five, diagnosed with ASD (n=4), who displayed a lack of peer interaction on the playground; typically developing children as well as children with other disabilities (n=32); and their classroom teachers (n=6). Two peers for each target child were trained as formal peer helpers. The goal was to improve the target children's interactions with peers and play and engagement on the childcare playground.

Setting. The experiment occurred on the subjects' inclusive childcare playground, which contained different areas of play such as sandboxes, a climbing and sliding structure, a concrete track for riding tricycles, and a Sound Path (Kern & Wolery, 2001).

Materials. A unique song with the intention to increase positive peer interaction and meaningful play and engagement during outdoor play was composed for each target child. In addition, an outdoor music center (Music Hut) with various musical instruments was added to the playground (Kern, Marlette, & Snyder, 2002).

Experimental Design. Using a multiple baseline design across four subjects, the effectiveness of the intervention was evaluated. Procedural fidelity data on teacher

and peer task behaviors were recorded as well. Four sequential conditions (Baseline [Condition A]; Adaptation of the playground [Condition B]; Teacher-mediated intervention [Condition C]; Peer-mediated intervention [Condition D]) were implemented for all subjects, except Condition D, in which only three subjects participated.

Procedure. Prior to the construction/availability of the Music Hut (Baseline) the subjects' engaged in playground activities without any instruction. With the adaptation of the playground (Condition B) the subjects were encouraged to play with the instruments on the Music Hut, then left alone. During the teacher-mediated intervention (Condition C), the unique song was sung in the Music Hut by the teachers with subjects and voluntary peers. Teachers trained the formally selected peers to mediate the intervention. The same song was sung by peers buddies and subjects in the Music Hut during the peer-mediated intervention (Condition D). The teacher's support was gradually faded out (see Case Vignette: Phillip).

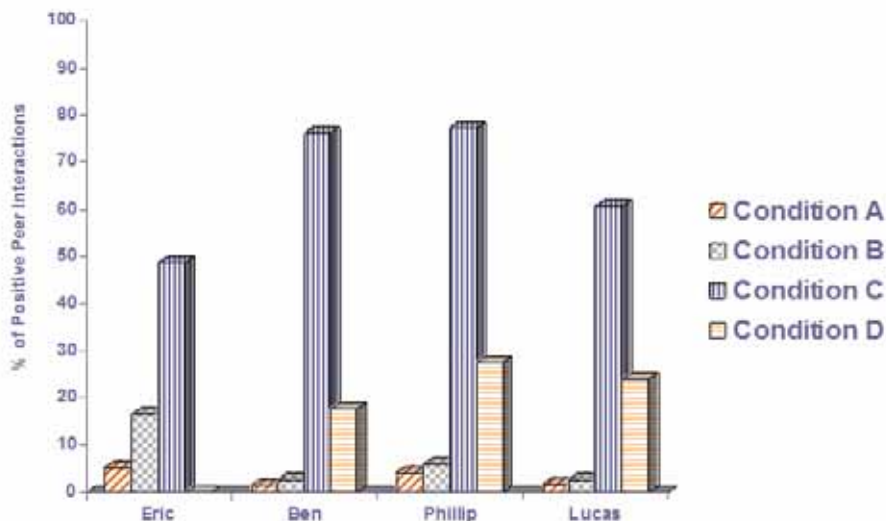
Measurements. Categories of interaction behaviors were coded through direct observation using a 15-second momentary time sampling recording procedure.

Reliability. Reliability checks were carried out on an average of 36.8% of total observations within each phase and for each child. The overall interobserver agreement was 98.2%.

RESULTS

Results of this study suggest that prior to the musical adaptation of the playground, the targeted children had few positive peer interactions on the playground (\bar{M} =3.2%). The musical adaptation of the playground enhanced positive peer interactions slightly but not significantly (\bar{M} =7.1%). The teacher-mediated intervention resulted in an immediate and significant increase in positive peer interactions (\bar{M} =66.2%). With the exception of one teacher, the teachers were observed to have a high ability to implement the intervention (\bar{M} =84%). Peers participated and modeled the tasks on a high level (\bar{M} =85.3%). Peer interaction, meanwhile, decreases during the peer-mediated intervention (\bar{M} =21.1%) but significantly improved compared to both the playground adaptation and especially the baseline. Play and engagement increased significantly for three subjects and remained the same over conditions for one subject.

FIGURE 3. Mean (M%) of positive peer interactions for each target child by each condition of the playground study.



CASE VIGNETTE: PHILLIP

Phillip was a friendly four-year-old boy with a sense of humor and a good temperament. He was diagnosed with ASD and had particular difficulty with interacting with classmates and engaging in meaningful play. When his inclusive preschool class was let loose to run around on the playground, he wandered around aimlessly, flapped his arms, spun a leaf, or sat on a bench, unless his teachers involved him in a meaningful activity such as riding a tricycle. Sometimes children trailed around after him and engaged him in a little chasing game. Phillip did not know how to approach his classmates appropriately and frequently pushed or screamed at them. As play progressed, peers frequently teased him or were scared and run away. Phillip's Mom and teachers were not pleased by the children's interaction. Phillip's Mom said she didn't like her son "being all by himself or rough to friends" while others played nicely with one another.

The music therapist observed Phillip's and his peers' behavior on the playground. She approached Phillip's classroom teachers Rebecca and Patricia and they engaged in defining the problem the children have. Together they evaluated possi-

ble strategies to improve Phillip's and his peers' playground interaction. Rebecca said that Phillip is amazingly adept in participating in musical activities. At the next interdisciplinary team meeting, Phillip's teachers and the music therapist suggested a music therapy intervention aimed to improve Phillip's playground peer interaction and play and engagement on the playground.

Earlier in the year, the music therapist initiated modification of the playground by adding an outdoor music center (Music Hut) on the childcare playground. She and her colleagues realized that the opportunity to engage in musical activities might enhance the overall playground experience, especially for children with special needs. Additionally, she created and distributed a booklet and CD with songs incorporating instruments in the Music Hut for promoting therapeutic goals such as interaction, initiation, cooperative play, self-expression and awareness, attention, and body control among teachers.

The Music Hut enhanced meaningful play and engagement for many children with and without disabilities, but did not improve Phillip's peer interaction. Phillip's Mom and other specialists agreed that an individualized song intervention, including individualized education goals and strategies commonly used with Phillip as well as peers as formal and informal helpers, then embedded by Phillip's teacher in the daily playground routine would be a suitable treatment option to achieve positive peer relation and also lay the foundation for friendship. After staff training, identifying Justin and Jacky as Phillip's peer buddies, Phillip's unique song was introduced to his class.

Shortly after, Phillip and Justin held hands and ran across the playground to the Music Hut, where Rebecca waited for them. Both were playing the gong in a loud fashion while singing, "I want to play the gong with you." Justin wanted to know if this song is called Phillip's Groove and jumped joyfully up and down when his teacher verified it. Next, Phillip initiated dancing and signed, "I want to dance with you." He took Justin's hand and spun around with him. His eyes were sparkling and Justin commented, "This is my favorite part." Later in the intervention, Rebecca stepped out of the Music Hut and only provided support, when needed. When Jacky sung and played, Phillip was in awe with her and synchronized his play with hers. Leaving the Music Hut the friends gave each other a big hug, signed thank you and waved good-bye.

The music therapy intervention enables Phillip to relate to his peer buddies and finds both musical and social pleasure. Phillip's Mom and teachers conclude that the song intervention is very successful in improving Phillip's quality of playground life.

Discussion

This cumulative study was designed to evaluate the effects of embedded music therapy interventions using songs and an outdoor music center on the performance of young children with autism during daily routines in an inclusive childcare program. It also examined teachers' ability to implement the interventions after receiving training, and the effectiveness of peer-mediated strategies to increase interactions on the playground.

The series of studies provided the following findings. Individualized music therapy interventions were effective in increasing the independent performance of the children within their childcare program. These findings are consistent with the reports from numerous formal and anecdotal case studies in music therapy, in which interventions were applied to improve core difficulties in children with autism in self-contained settings (e.g., Allgood, 2002; Alvin & Warwick, 1991; Brownell, 2002; Edgerton, 1994; Gustdoff & Neugebauer, 1997; Nordoff-Robbins, 1977; Schuhmacher, 1999; Snell, 2002; Wimpory et al., 1995). However, this study expanded upon previous studies in the field by showing that acquisition of social and adaptive skills occurs when the interventions are embedded within the daily routines and events. Further research should investigate if music therapy interventions embedded in daily routines can facilitate the development of other skills and if they are beneficial to children with special needs other than autism.

Songs are a powerful means of conveying therapeutic goals. In eight of nine cases, the songs produced desirable outcomes. These findings support current practice with children with autism (Baker, 1992; Cole-Currens, 1993; Furman, 2001; Gottschewski, 2001; Williams, 1996) and provide evidence that greeting songs can be effective during difficult separations from caregivers. They also replicate earlier studies in which music was used to facilitate memorization of sequences (Gfeller, 1983; Jellison & Miller, 1982; Wolfe & Horn, 1993), as well as to improve social skills (Stevens & Clark, 1969; Brownell, 2002). However, previous studies did not examine the use of songs with children with autism for transitioning and memorization of multiple-step tasks, nor did they take place in an inclusive childcare program. Since the three studies were not comparison studies, it is not known if other songs or other interventions would have been equally effective or more so. Only the multiple-step tasks study provided evidence that the songs were more effective than the verbal presentation of a sequence. More studies are needed that compare the effects of a variety of songs and other interventions on the behavior of young children with autism.

The musical adaptations of the playground facilitated the involvement and motivation of children with autism to interact with peers. However, the combination of the musical playground equipment and individualized interventions are needed to obtain the desired outcomes. This is consistent with findings in another study of playground modifications (Kern & Wolery, 2001, 2002) and is described in the literature (e.g., Dunst et al., 2001; Nabors et al., 2001; Sandall, McLean, & Smith, 2000; McWilliam, 1996, 2000a, 2000b; Wesley, 2004). That is, environmental adaptations and teacher-mediated interventions are often necessary to meet the children's learning needs. In general, playgrounds need to be seen as educational/ therapeutic environments. More studies that apply music therapy on playgrounds, both to children with and without disabilities, are needed.

A music therapy collaborative consultative approach is effective in enabling teachers to implement interventions based on music therapy principles successfully in daily classroom and playground routines, when staff development activities and ongoing consultation is provided. This replicates and expands upon earlier studies showing that teachers can effectively implement interventions related to other disciplines in ongoing activities when support is provided (Garfinkel & Schwartz, 2002; Sewell et al., 1998; Venn et al., 1993; Wolery et al., 2002). However, in previous studies, interventions were not based on music therapy. Furthermore, there is a correlation between correct implementation and the target children's skill improvement. Effective staff development activities and ongoing collaboration are critical components for appropriate and successful implementation of teacher-mediated interventions based on music therapy. Although there are many ways of providing therapeutic services in early intervention, the collaborative consultative model of service delivery is desirable. It leads to more comprehensive and holistic interventions, and incorporates recommended practice and policy in early intervention. More research explaining the effectiveness of a music therapy collaborative consultative model of service delivery in the child's natural environment is needed.

Overall, music therapy interventions broaden social experiences of young children with autism. Peer-mediated strategies, as used in Experiment III, were effective in increasing peer interactions and meaningful play on the playground. At the same time, the interventions facilitated the positive involvement of young children with autism in group-oriented activities and provided solid foundations for developing friendships with peers.

Finally, this study demonstrates the potential benefits of a cumulative case study design for music therapists working in early intervention. Single case designs enable us to evaluate clinical practice and consultation with other professionals, and to ask important questions about the practices and principles of music therapy

in a quantitative and experimental way. However, single-case experimental designs are limited by the small number of participants. In order to generalize, replication with multiple participants is warranted. Nonetheless, this series of studies intended to be a contribution to establish music therapy as a widely recognized related service in Early Intervention/Early Childhood Special Education.

Conclusions

This cumulative case study supports the contemporary model of service delivery in early intervention/early childhood special education, and shows that music therapy interventions can be meaningfully embedded in ongoing classroom activities and routines. The music therapy collaborative consultative approach was effective in enabling teachers to implement the interventions successfully. Through individualized song interventions, children with autism acquired and improved skills and social interactions with peers in the natural environment. The involvement of children with and without disabilities in music provided opportunities for establishing friendships.

Collaborative consultation, widely employed elsewhere in early intervention/early childhood special education to promote program sustainability, is an appropriate and effective way of providing music therapy treatment. Indeed, it allows for the expansion of music therapy services. Overall, music therapy enhances services for young children with autism. However, training of music therapists in collaborative consultative methods of service delivery, along with continued research into the effects of embedded music therapy interventions in inclusive childcare programs, is warranted.

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*When dialogue fails.
music therapy with
elderly with neurological
degenerative diseases*

Ochsner Ridder, Hanne Mette

**Keynote 4 on Friday morning, June
18th, 09:45**

In a PhD-research from Aalborg University I have used a mixed method case study design, where I integrated quantitative heart beat measurements and a qualitative hermeneutic analysis on responses given by participants in music therapy. In this paper I am not going to present the research. I will use the opportunity to present one single element from the work. This will be a focus on a clinical strategy for building up music therapy sessions with persons who are gradually losing cognitive abilities and suffer from severe neurodegeneration.

I shall present four levels or steps in the clinical setting, where different strategies are used in order to compensate for missing memory function and missing abilities to communicate. In addition to being part of the doctoral thesis (Ridder 2003), these ideas are based on clinical music therapy work at a geronto-psychiatric unit since 1995. For background information on music therapy with this client group see Aldridge (2000), Brotons (2000), Clair & Bernstein (1990), Fitzgerald-Cloutier (1993), Tomaino (2000), and Wigram et al. (2002).

Neurodegeneration

The client group in this presentation are people who have neurological problems; elderly people where symptoms in the brain are related to symptoms that the person can describe or we, who know the person, can observe. Symptoms related directly to neurodegeneration are here defined as primary symptoms. In this sense, secondary symptoms are symptoms that are not related directly to the changes inside the brain, but related to changes in how these people experience their environment, how their relation to other people is changed, and how they are stigmatized by too little understanding of their illness. Basically, secondary symptoms are related to missing communicative abilities.

My hypothesis is that these secondary symptoms are symptoms that we might be able to change by music therapy, without being able to cure the primary symptoms.

First I want to give a very short introduction to the client group. We have different categories of neurological disorder (Epilepsy, Stroke, Multiple Sclerosis, Developmental neurology) and in this paper the focus is on degenerative diseases. Degenerative diseases are generally associated with Parkinson's disease or Alzheimer's disease. Further more we see Lewy Body diseases, Multi-infarct dementia, Pick's disease, Huntington's disease, Creutzfeldt-Jacob disease, and other degenerative diseases.

Degeneration is seen when something declines or is reduced, and neurodegeneration is seen when a so-called normally developed brain loses function because of pathological disorders in neurons, in supporting glia cells, in neurotransmitter activity, or in recurrent vascular disorders, that are changes in blood supply. Most degenerative diseases are chronic, progressive, and lead to atrophy (Gade 1997). I will not go into details with these different types of damages of brain tissue, but illustrate the degeneration with one example; the formation of plaque. This is often

illustrated as small enzyme-‘scissors’ cutting out certain proteins from the healthy APP-molecules (see picture 13-15 at www.alzheimers.org/rmedia/graphicshigh-res.htm). This gives a formation of beta-amyloid plaque that stick together outside the cell in clumps. These clumps of cell trash disintegrate neurons. At a certain age we might all have small clumps of plaques in our brains. But when the amount increases, and the clumps are seen in certain patterns, then they are markers of a pathological picture, as in Alzheimer’s disease.

Most degenerative diseases lead to atrophy. With cortical atrophy brain tissue is shrinking, e.g. when neuronal connections are lost. Atrophy can be located on different kinds of brain mappings, and in this way give some hints of a certain pathological picture.

Atrophy can be focal, located to a specific structure, regional, as on the picture with regional atrophy involving the frontotemporal areas (see picture at: medlib.med.utah.edu/.../CNS/CNSDG008.html), or diffuse, causing stray shrinkage, which is seen in vascular dementias.

Metaphorically we can describe the frontal lobes as the conductor of a very big orchestra, or as a net browser that direct us when we net-surfe, or as our decision maker. The frontal lobes are important to empathy, creativity, identity and sociality. But without the orchestra (the other parts of the brain) – or without contact to the orchestra – the conductor will have big difficulties in playing. And without a net bristling with information, there will be nowhere to browse, or no foundation for making decisions (see Goldberg 2001).

The atrophy and the neuronal degeneration are in different patterns markers of different degenerative diseases. Depending on which cortical location and which networking systems are involved, we see primary symptoms where the person experiences problems with perception, executive function, initiating movements, and short-term memory. When areas deeper in the brain – in subcortical areas – are damaged, apathy and depression are very often seen and the person might lose ability to coordinate and time movements and responses, and will have big problems in recalling both recent and remote information (Zillmer & Spiers 2001).

MEMORY

Our ability to memorize influences all aspects of daily living, even how we ‘remember forward’: how we respond to new experiences and how we plan our day. Before I continue with a short overview on memory function, I want to include a glimpse from a music therapy session with Mrs F.

Mrs F suffers from frontotemporal dementia (Pick's disease) in an advanced stage. This means that especially frontal lobe and anterior temporal lobe is damaged. The atrophy in her brain might look like the picture with the link above to medlib/Web-Path. Mrs F needs help in all activities of daily living. She cannot find her way to her living room or the toilet. She shows symptoms of apraxia and needs help or guidance when dressing or eating. She suffers global aphasia and her language is reduced to a few particular words that she repeats over and over again. Symptoms of amnesia are severe and she does not recognise her sister who is her only relative and to whom she has been very close. Mrs F constantly ambulates. She walks and walks, trying all doors on her way. If her walking is hindered she gets angry and aggressive, and hits staff and peer residents.

In the individual music therapy Mrs F will equally walk about in the music therapy room. But then her attention is suddenly caught by the familiar songs that I sing to her. She walks towards me and seems attentive and looks intensively at me. She then comes to sit down besides me for a while, sometimes falling asleep after a few songs.

Mrs F suffers from amnesia and has "lost" her memory. Does this then mean that she is not remembering anything at all? In order to answer this question, I shall focus on different memory systems.

First of all, memory can be divided into a short-term and a long-term memory function. Normally both are involved, when we are exposed to an external input and respond to this. And both functions are involved when we learn new things and recall episodes or facts.

Short-term memory is our working memory that is influencing attention and executive functioning and is related to cortical structures of the brain.

Long-term memory is not only an ability to remember things from long ago, but more specifically it is our ability to register information, to organize the information in a meaningful way, and our ability to recall the information when needed. This means that long-term memory has to do with encoding, storing and retrieving information (Zillmer & Spiers 2001, p. 160). Memory functions can not be separated, as they seem to overlap and influence each other. Still, it makes sense to separate the memory system in more subsystems.

Long-term memory is here separated in a declarative and a non-declarative system. Declarative memory is what is explicit and what we are conscious about, e.g. when

we remember facts. People with a developed semantic memory are good to have on your team, when playing Trivial Pursuit.

Episodic memory is remembering personal experiences or episodes, e.g. your first travel to Paris or Jyväskylä, or other exotic places.

Declarative memory can be damaged by single lesions in the brain. This is not the case for non-declarative memory that refers to a variety of memory functions, e.g. the memory of routines, of biking, or playing “für Elise”, or how we adjust our behaviour to implicit rules in an exclusive restaurant or in a church.

Short-term memory (or working-memory) is a component of long-term memory, but mainly involves cortical structures, especially prefrontal cortex. In long-term memory non-declarative memory (or procedural memory) involves various sub-cortical structures in the brain in a dynamic integrated system. The first signs of Alzheimer’s disease are loss of episodic memory in a process where Hippocampus (a Limbic structure) is isolated from Cortex.

What I mainly want to stress with this, is the idea of multiple memory systems, e.g. presented by Joseph LeDoux in 1998.

In the case of Mrs F, the degeneration of her brain has damaged pre-frontal cortex and therefore especially short-term memory functioning. Additionally she seems to have lost semantic and episodic memory. When I in music therapy sing to her, it might be a way to activate procedural memory systems, priming less damaged sub-cortical structures that are components of our complex memory network. Memory and identity are strongly connected, and therefore memory functioning and alternative ways to facilitate memory are central to clinical music therapy. Not only neuro-degeneration affects memory. *What* and *when* we memorize is dependent on attention.

Attention

When Mrs F approaches me in the music therapy sessions she seems to pay attention to me (the music therapist), to my sounds, or to the song. When you see Mrs F walking about at the unit, you see that she is attentive to door knobs. She will try every door knob she passes. But otherwise it is very difficult to catch her attention.

From research in mother and infant relationship Daniel Stern, in his book from 1977, writes that when a mother stimulates her baby too little, the child will lose interest and not pay attention to what she is doing. If the mother is stimulating the baby too much, he will turn away or start crying.

But “When the level of stimulation is more moderate, somewhere between the two extremes, his attention will be more easily captured and maintained” (Stern 1977).

In many brain dysfunctions we see symptoms of attention disorders, where the person is not able to focus attention, to divide attention (being able to do more things at a time), and to sustain attention.

What Stern tells us to do in order to catch and maintain attention is to stimulate, not too much and not too little, but at a moderate level. Although Stern is dealing with infant research, he describes basic human interaction that is also relevant to this population.

Arousal

In order to illustrate attention regulation I want to integrate theories of arousal. A person with attention deficits might have big difficulties in processing stimuli. If the television is turned on with loud sounds and flashing images this might be inputs that intensify the chaos that this person might feel. With too many inputs the person ends up in a hyper-aroused stage showing restlessness, vigorous gestures, speedy talk, and a fast heartbeat. A person in a low state of arousal, a hypo-aroused state, shows little activity, apathy, withdrawal, slow heartbeat, and little verbal and nonverbal communication.

At a balanced and moderate arousal level, in a situation with moderate stimuli, the person is most attentive to the environment and to own needs. At this balanced arousal level the person has most possibilities for optimal performance (An elaboration on *performance* and *performance as health* can be found in Aldridge’s book from 1996).

As a result of neurodegeneration and of either hypo- or hyper-arousal a person might lack abilities of focussing and sustaining attention, memorizing, and controlling and timing movements and responses. Having these deficits causes problems in communicating and entering dialogue with other persons. Communication and interaction depends on synchrony and reciprocity, and from research done by

Steven Malloch (1999) and Colvin Trevarthen (1999) we see that even infants *time* and *adjust* their responses in communication with their mother.

Communication and dialogue

Neurdegeneration might lead to primary symptoms showing a person who is no longer able to communicate. Not being able to communicate leads to secondary symptoms. In a paper from 2001 David Aldridge writes:

”When dialogue fails then we have alienation and despair ... Patients may be forced into a silence that they have no possibilities to neither transform nor structure, they are banished from the social to an isolated and degenerated self (Aldridge 2001)”.

Facing these severe implications of communication breakdown, Aldridge goes further and calls neuro-degenerative diseases dialogic-degenerative diseases. The word dialogue stems from Greek and means words/thought/reason (logos) between (dia). This implies an understanding and exchange of ‘logos’ ‘between’ two individuals. Logo’s counterpart is psyche, in Greek mythology the personification of the soul; of mind and spirit. In this sense dialogue is seen as an understanding and exchange between two individuals of both psyche and logos – of both reason and feelings. Seen from a dialectical or rational viewpoint emotions are illogical and does not belong to logos. Seen from modern neuropsychology (e.g. Damasio 1994) feelings are essential in human ability to judge and make decisions. When dialogue fails because of neurodegeneration we are not able to share reason and feelings, and it becomes difficult to meet our psychosocial needs.

Psychosocial needs

This leads me to a short introduction on psychosocial needs and on the work of the psychologist Tom Kitwood who has done important research in dementia care. Kitwood defines a need as ”...that without which a human being cannot function, even minimally, as a person” (Kitwood 1997, p. 19). Instead of describing agitated and aggressive behaviour as problem behaviour, Kitwood describes these as attempts at communication that is related to need.

In order to describe the subjective world of dementia, Kitwood describes a cluster of five great psychosocial needs: comfort, attachment, inclusion, occupation, identity, which come together in a central need for love. When psychosocial needs are not met secondary symptoms of the degenerative disease might occur. Symptoms like: repetitive behaviour, catastrophic reactions and situationally inappropriate behaviour.

How is it possible to meet these basic psychosocial needs? Here Kitwood puts up 12 positive interactions that might function as strategies to meet psychosocial needs. I will not elaborate on these, but focus on three specific strategies: validation, holding, and facilitation that are described as distinctly psychotherapeutic techniques.

VALIDATION

Kitwood describes validation as an attempt to understand a person's entire frame of reference, even if it is chaotic or filled with hallucinations (Kitwood 1997, p. 136). It is a way of acknowledging a person's feelings and responding to them. If an old woman with dementia tells me she wants to go home to her mother, a reality orientation approach would be to tell her that her mother has died many years ago and that she has to stay in the residential home. A validation technique would be to respond to her feelings of being unsafe and not feeling at home where she is.

HOLDING

Holding is a term that is also used in client-centred therapy, e.g. by Rogers (1951) and Winnicott (Davis & Wallbridge 1981). Kitwood describes holding as providing a safe psychological space, a container, where tension, vulnerability, and conflicts may be exposed.

FACILITATION

Facilitation is important to all music therapy, as we as music therapists focus on creativity and resources, enabling a person to do what otherwise he or she would not be able to do (Kitwood 1997).

Building up the music therapy session

I have now given a broad introduction to themes on Neurodegeneration, Primary/secondary symptoms, Multiple memory systems, Attention and arousal, and Dialogue and psychosocial needs.

All themes are relevant to how the clinical music therapy setting is built up – when working with clients with a dialogic degenerative disease.

In the following I focus on 4 steps in the music therapy session with a client group suffering from severe dementia. An inclusion criterion for participants in the study (Ridder 2003) was among other criteria, that they would show symptoms of agitation; that they in periods of the day would show hyper-arousal. All six persons are residents at a geronto-psychiatric unit, referred to this place because daily care became too problematic at the local residential home.

1. FOCUS ATTENTION

I start every session by singing a special song. Especially in music therapy with children there is a tradition of using hello-songs. With participants having severe memory deficits it makes sense cuing the beginning of the session with a song in order to focus attention and compensate for missing short-term memory and in this way preparing the person to what is going to happen. A song, as well as contextual and social cues, activates memory traces in the brain, and speed up the retrieval process. Contextual cues organise the person in time and space. The person might at some level recognise the room, the songbooks, and the sofa we sit in. Social cues depend on our interaction; the way I, as the therapist, greet and welcome the person and what we do together.

Clients seldom recognise me, if we meet outside the music therapy room. But when we then enter the room and the person sees me, the songbooks, the furniture, and hears the hello-song it is very often clear that he or she recognizes me and has an understanding of what is going to happen.

Some clients need several sessions, depending on cortical functioning, before some idea of the music therapy is constituted. This means that the first many sessions might deal with establishing a structure by stability and cues.

2. REGULATE AROUSAL LEVEL

When it is possible to catch the attention of the client and facilitate some understanding of what is going to happen, the next step in the session comes to the foreground. Now it is relevant to regulate arousal level to a moderate level, where it might be possible to *maintain* attention. We have seen that there seems to be a relation between medium levels of arousal and environmental attention.

The structure of the music therapy might in itself have an indirectly regulating effect. Apart from this, the therapist can regulate arousal level by different tech-

niques. Being aware of musical elements (timbre, tempo, volume, pitch, timing...) it is possible to either decrease or increase arousal.

It is possible to regulate arousal level making use of social elements. The therapist can make use of his or her own presence in order to regulate. Rhythm, proximity, attitude, and expectations might be used to either stimulate or calm down the client.

In the example with Mrs F the singing at some level has a calming effect on her. In order to assess arousal level I registered the number of times she verbalized one of the two words she has left.

In our 2nd session she used these words more than 500 times, but the number decreased dramatically. This is not information enough to tell if her arousal level generally decreased, and needs to be combined with other observations. Additionally I measured Mrs F's heart rate by daily measurements in the same time period as the music therapy. Heart rate was measured daily in 5-second intervals the week before a month with 20 music therapy sessions, and the week after. A statistical t-test showed a highly significant decrease in Mrs F's heart rate. In connection with more observations this points to a decreased arousal level after the music therapy, - even a whole week after the music therapy ended. In the study 5 of the 6 participants showed significant decreases in heart rate after music therapy.

3. DIALOGUE

Now, after having built up a recognizable structure using stability and cues, and having used arousal regulating techniques, we have the potential for dialogue and meeting of psychosocial needs. When dialogue fails and the person with a degenerative disease is isolated from social contact, it is here we have a possibility of breaking the isolation.

The songs in this part are not used to form a structure, or to regulate, but mainly to meet the person. There seems to be certain songs that are strongly connected to life story, that represent a certain period of life, and where certain feelings are bound. If it is possible to find these personal songs there seems to be a key to memories that are still there, in spite of severe amnesia. The therapist shares the feelings that are represented in the songs with the client, in a way that is adjusted to the client's capacities.

4. Conclusion

Like a piece of music it has a stabilizing effect when the music therapy session is concluded in a stable form. Again the structure is built up by stability and cues and with the use of one or more songs that signalise closure and stability. When the session has a clear form, *time* is also given a form. This might give the client an understanding of continuance and stability.

Besides ending the session, the therapist must ensure that the client is guided to a new secure basis. The carry-over-effect of the music therapy is better maintained, if the therapist ensures that the client is not dropped into a new chaos, but led to basis, where he or she feels secure. This means close collaboration with staff that ‘takes over’ after the therapy.

SUMMING UP

In order to compensate for memory and attention deficits different kinds of cuing gives stability, and constitutes the structure of the therapy. The songs function as cues compensating for specific memory deficits by involving other memory functions in a multiple memory system (see table 1.1)

The next step in the music therapy is to regulate arousal level to a balanced level, where the person shows most environmental attention. Musical elements and social elements are important in the regulation. A state with moderate arousal and environmental attention enables the therapist to enter dialogue with the client. By using psychotherapeutic techniques and songs with a personal meaning it might be possible to meet psychosocial needs. Concluding the session is part of the structure and ensures stability.

TABLE 2. 4 steps in the music therapy session

| Level | Components | Aspects |
|--|---|----------------|
| Focus attention | Structure: stability and cues. Songs as cues | Constitutional |
| Regulate arousal level (environmental attention) | Musical and social elements. Songs that stimulate/sedate | Regulative |

TABLE 2. 4 steps in the music therapy session

| | | |
|-------------------|--|-------------|
| Dialogue | Focus on psychosocial needs. Validation, holding, facilitation Songs with personal meaning | Dialogical |
| Conclusion | Structure: stability and cues. Songs as cues | Integrative |

MRS D

At the European music therapy conference in Finland I had the opportunity to illustrate the different steps in the clinical setting by short video clips. I do not have that possibility here. Instead I will refer to the case of Mrs D where the arousal regulation was important in order to be able to enter dialogue.

Mrs D's diagnosis reads vascular dementia with frontal character and confusion of cerebellum. She has good verbal functioning, but never-the-less scores 5 out of 30 points on the Mini Mental State Examination (Folstein 1975), indicating severe dementia. According to the CMAI (Cohen-Mansfield's Agitation Inventory, Cohen-Mansfield 1996) she shows agitated behaviour several times a day for longer periods. She shows verbal aggressive agitated behaviour by shouting and scolding, and physically aggressive agitated behaviour when she hits staff or throws her dinner, china or other things on the floor. She is medically treated for both depression and psychosis. Mrs D has recently broken her hip bone and staff prefer her to remain in the wheelchair during music therapy. She hears very badly, but does not want to use hearing aids.

Before our 6th music therapy session Mrs D has been very upset most of the morning. Already when I enter the unit I hear Mrs D shouting. As usual before a session, I have a word with her contact staff, before preparing the last things for the session. I hear Mrs D shouting for coffee, and blaming staff that she is not allowed coffee when she wants. A staff member tells her that she has just drunk coffee, which makes her even angrier. Later, having prepared the music therapy room, I open the door to fetch Mrs D and she is already close to the music therapy room. A peer resident is pushing her wheelchair down the corridor. On the way the wheelchair has collided with a rollator, belonging to another resident sitting in an armchair. This resident is very angry, and so is Mrs D who wants the involuntary drive to stop, and shouts the best she can. Mrs D continues shouting in the music therapy room, but does not make any attempt to leave the room. Her comment when I start singing is: "Oh, belt up, #" and after the song she asks in a schoolmistress' voice: "Well, are

you trying to learn singing?” As usual, I give her my hand and greet her during the first song. She takes my hand, and keeps holding it, which is in contrast to her verbal rejections. I start singing the next song, but do not look at her as I assume that would be too demanding. Suddenly in the refrain she joins in the song. She sings the words, but in a very angry manner. In the end of the song she corrects the text I am singing. I repeat the line like she wants it, and after a few more scornful comments she remains silent. After the 4th song Mrs D blinks and in the 6th song she closes her eyes for shorter periods. She does not fall a sleep, but often closes her eyes during the altogether 17 songs. I extend the session as I think she needs the rest after a turbulent morning. I sing songs that in the beginning are “neutral”. I have the feeling that too “soothing” songs could be provocative to her, but gradually I introduce more “melancholic”, slow, minor scale songs. When I sing the last song – a song that is used to conclude the sessions and that she likes very much – she moves her head slightly from side to side in beat. After the song she gives me a smile. I ask her if she wants to go out into the garden where she likes to be on warm summer days, and she answers in a very attentive and clear manner: “We can do that. The weather is nice today ... lovely ... it seems to be fine today”.

In the beginning of this session it is not possible to enter dialogue with Mrs D. I here use the songs to keep the structure in order to indirectly regulate her arousal level. I am accepting her tension, but without matching or validating it. It is important to notice that Mrs D has damages in her frontal lobes and that she is not able to be her own ‘conductor’. When she is in this hyper-aroused state it adds to her anger, if I mirror or match the anger. After the first two minutes of the session Mrs D does not join in the singing or verbalise anymore, and there is a clear decrease in her heart rate that is registered during the whole session.

The contextual and social cues make it clear to her what is going to happen and support her memory processing, and it is possible to regulate her arousal level by the songs.

She calms down and later seems attentive and open for dialogue, and I sing familiar songs that I feel share her feelings of sadness or melancholy. In this way I use a validation technique acknowledging her emotions and responding to them.

After our 8th session, where Mrs D once again has been very upset in the morning, she is very relevant and clear at the end of the session in spite of severe dementia. She is able to put in words that the music therapy made a change to her. This is unique as none of the other participants in the study were able to communicate their thoughts verbally in this way. But although they were not able to talk, the music

therapy shows that they were offering communicational cues to others and were capable of entering into dialogue when the music therapy sessions were built up in a way that compensate for their deficits. Mrs D concludes:

“It was good that you came today (laughs) ...

I totally forgot why I was sad.

But I was ...

Never mind (laughs) ...

Well ... which song are we going to sing tomorrow?”

Thanks to

I would like to thank David Aldridge for his indispensable guidance and supervision when I carried out the research and Tony Wigram for organising a very inspiring research milieu around the doctoral programme at Aalborg University. And thanks to staff and residents at Nursing Home Caritas in Denmark.

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*The principle of
polarisation used in
working with
schizophrenic patients*

Jensen, Bent

**Keynote 5 on Friday morning June 18th,
09:45-10:30**

Editors note: Check for the html version with all video and audio files on Music-TherapyToday.com (November 2005)

Abstract

Through a case with a schizophrenic man I will give examples of my clinical music therapy method working with schizophrenic patients. A key concept is the integration of polarities through musical improvisations.

The case starts as individual music therapy with a schizophrenic patient, becomes group therapy with another schizophrenic patient, and later on a mentally healthy person joins, and a band is formed. As the patient dropped out of the project a short time before the conference in Finland, an additional focus emerged: an attempt to identify reasons for the patient's withdrawal at a time where the music therapy seemed to be very successful.

The withdrawal from the band project is explored from several perspectives. A phenomenological understanding of schizophrenia is used to identify polarities central to the therapy. The patient is interviewed as to why he had to quit the project. Finally, the meaning of the patient's knowing that the case material is used in presentations to promote music therapy is discussed. Are there ethical problems?

At the same time this is a description of the complexity of schizophrenia and psychosis.

The presentation in Finland was a personal oral presentation. I decided to keep this form, well knowing that the text at times may be very brief. I therefore suggest that the reader listens to the music and sees the videos.

The case

This 30-year old schizophrenic man suffers from severe anxiety. He thinks he is possessed by the devil. At one point in his life he was at a crossroads where he had to choose between the devil and God. He chose the devil. He has a sense of guilt and feels responsible for the terrors of war.

Some years ago he was an eager amateur musician. He played the electric guitar in an amateur band, but when the lead singer died he blamed himself for his death. Later he had a falling-out with the other members of the band and, since then he has not played at all.

He told me that the psychiatrist said that his fantasies of the devil were not true; therefore he did not tell him about them any more. But for him they were still reality. In one session we agreed on making a title for an improvisation - we would play The Music of the Devil.

In this improvisation, he had the courage to play the guitar for the first time in two years. I played the keyboard with a violin sound and a bass sound.

MUSIC EXAMPLE

After our improvisations, we listened to our music together. Listening to the tapes of our improvisations he gradually found out that this devilish music actually also was beautiful.

For a whole year we improvised music weekly. The music Christian and I played was characterised by many changes in tempo and pulse, and changes between tonal and atonal music modes. We improvised on many different themes, and sometimes the only theme was to create music.

The music expresses both anger and anxiety, but also joy, longing and hope, and there is an intense and mutual dialogue.

VIDEO CUT 1 (FROM ONE OF OUR IMPROVISATIONS)

Conversation after an improvisation

After an improvisation on the theme of the devil we had this conversation: (italics in parentheses my interpretations)

I ask: ***Tp: Is it the music of the devil?***

Pt: Yes, I guess it is, he's hiding in the background (a sparkle in the eye) but there's also something divine (*he understands that his music is both devilish and divine at the same time*)

There is a spiritual guide

(he asks me) Do you hear voices when you play?

No (I say) Do you?

No, not when we play. Then I get into it, to do it as well as possible. It's a story, our story, otherwise it wouldn't be so pure..... *(He has 80 tapes with our music. He considers them his musical diaries)*

It would be good to find a singer or a drummer to play with us, but not someone who just says 1-2-3-4 – it has to be someone who can be a part of what we have. *(Now he begins to have dreams)*

INDIVIDUAL THERAPY TURNS INTO GROUP THERAPY

At one point he contacted the drummer of the band he played in 3 years ago, where the singer had died. This patient also was diagnosed with schizophrenia.

VIDEO CUT 2

They decided to make an advertisement to find a singer for the band.

A mentally healthy young man answered the advertisement and came to the audition. I was very nervous on their behalf - would he be scared away? They started by saying: You need to know that we are schizophrenic, not axe- murderers, but we hear voices and are sometimes sent to the closed ward.

They started the audition. He had brought a song he wanted to sing and was very nervous. They went to the instruments and played, cooler and more precise than ever. After the audition they said: “You are accepted. “

The intimate individual therapy has now turned into group therapy, so the music changes from rather free improvisations to more structured band playing. For Christian it was important to show the new singer how he and I used to improvise. In one session where the drummer was absent, Christian grabbed the chance to teach the new singer how to improvise. In the next video cut you can see how the singer tries to follow our crazy improvisations, with some success. Christian praises him. You could call it a kind of “opposite integration”. The normal person had to adapt to what Christian understood as his (schizophrenic) music. So he encouraged the normal singer to use his voice more freely.

VIDEO CUT 3 (SINGER IMPROVISES)

CD production and the first concert

They only played their own material and wanted to make a CD recording, so the music therapy room was turned into a recording studio. Christian's father joined us when we were mixing the CD, and took pictures for the cover and made the layout. Christian was very proud that he helped us.

Now they were ready for their first performance. It was at a psychiatric festival. Christian was very anxious about going on stage, and was scared that people might shout at him, so he wanted to sit down during the performance.

VIDEO CUT 4 (FROM CONCERT)

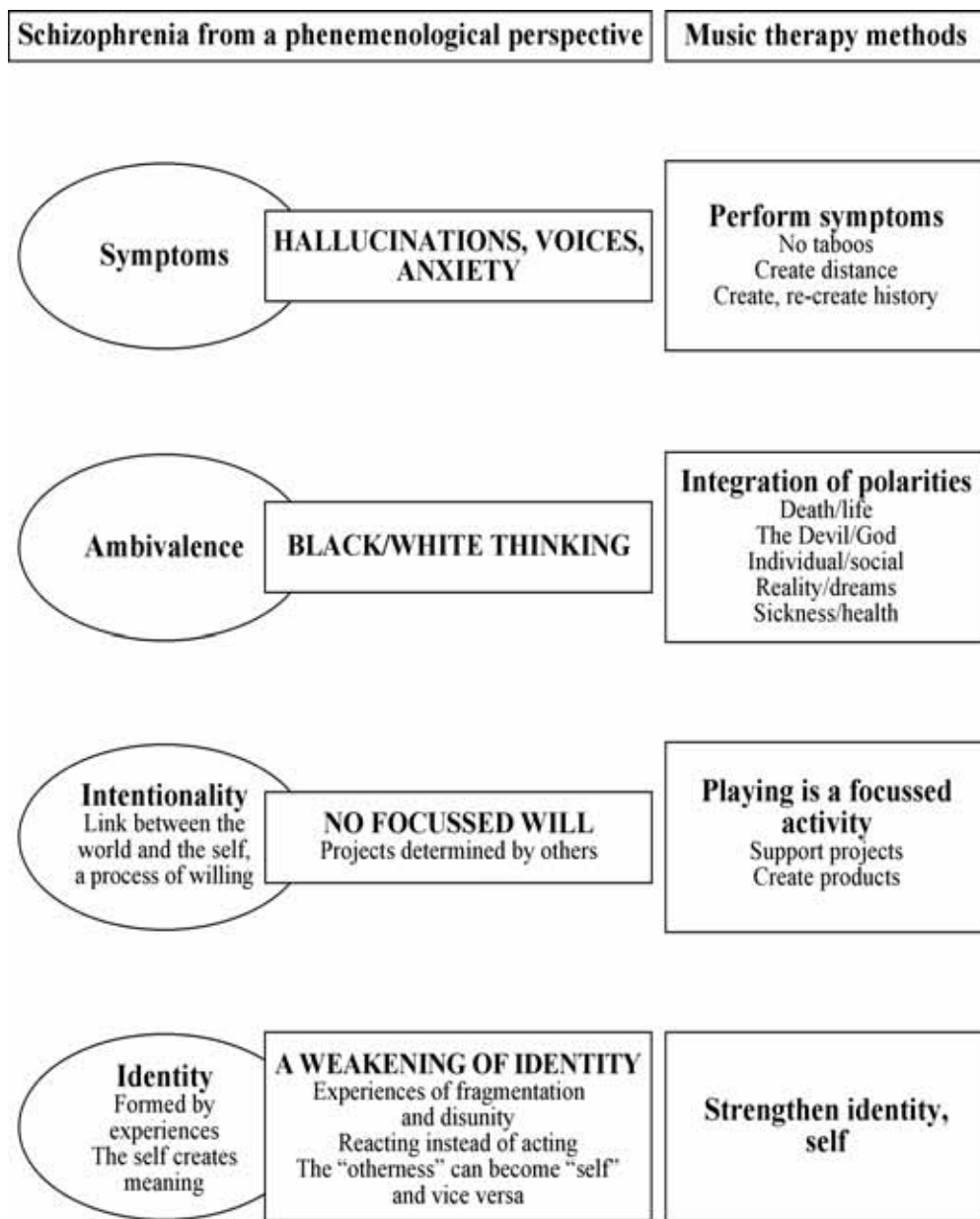
Some weeks prior to a festival for psychiatric patients where the band had planned to play, Christian suddenly wanted to stop in the band, which was totally unexpected to me.

I will try to look at this event from some different perspectives, to try to understand why this happened. Why was it necessary for the patient to quit the project, at a time where it seemed to be very successful?

These perspectives are:

- A model where I relate a phenomenological inspired understanding of schizophrenia with the music therapy method that I use with schizophrenic patients in general
- Identification of some polarities that I find central to the therapy
- Interview with the patient about why he had to quit the project.
- Discussion of the meaning of the patient's knowing that the case material is used for presentations and in the media to promote music therapy. Are there ethical problems?

FIGURE 4. The model



The model describes important aspects of the schizophrenic personality and music therapy methods used to address these issues. I will discuss the model starting at the base, as I find that weakened and fragmented identity from a phenomenological perspective is the primary characteristic of schizophrenia.

Identity, sense of self, consciousness

Seen in a phenomenological perspective (Wiggins, Schwartz & Northoff 1990) the identity and sense of self is formed by experiences. There is dialectic between the experienced world and the experiencing self. Mental life includes both the world and itself as a part of the world.

In schizophrenia the identity is weakened, objects and myself can appear splintered and fragmented.

Laing (1960) talks about “ontological insecurity”, a condition in which I become radically uncertain of my essential self.

In normal mental life the totality of experiences is sensed as “mine” in the sense that “I” am part of it. For the schizophrenic person aspects of “myself” can become “other”, and essential features of things and other people can lose their “otherness” and become “self”. (Wiggins, Schwartz & Northoff 1990)

Some psychiatric terms for this phenomenon are: ego weakness, ego boundary disturbance, depersonalization, derealization and breakdown of the unity of the self.

INTENTIONALITY

Every mental process is an awareness of something. Subjective experience is always directed toward something outside of itself. In this sense the concept of intentionality refers to the link between experiencing subjects and the experienced external world. But consciousness is not only an awareness of objects, it is also a process of willing, of making plans and acting on them. (Davidson 2002)

Husserl (1983) defines an active part of intentionality where the ego is involved, and a more passive “ego-less” automatic or receptive part of intentionality. Davidson (2002) suggests that people with schizophrenia perhaps mainly identify themselves with the way they are moved and affected, forgetting their own activity. Their sense of personal identity is then one-sided, they have an experience of the

self as an object rather than as an agent. The schizophrenic person reacts instead of acting.

Schizophrenic people often talk about how they are controlled by a lot of things in their life (e.g. TV or certain people) but they will rarely talk about things they can control. And they perceive people in their life as powerful, but regard themselves as powerless.

A schizophrenic can appear active, but even then he may not experience himself as the origin of his projects. Often a schizophrenic person thinks that his projects are determined not by the ego but by another person, a thing or a certain event. (Davidson 2002)

AMBIVALENCE AND SYMPTOMS

In schizophrenia, black/ white thinking is dominant. The schizophrenic person has difficulties in integrating polarities. As a consequence of problems with identity, intentionality and integration the schizophrenic person often experiences anxiety, hallucinations, delusions or voices which usually is experienced as painful.

I will relate these four concepts of the model - identity, intentionality, ambivalence and symptoms - to the clinical music therapy method that I use with schizophrenic patients. I will start by addressing the issue of symptoms, because it is fundamental that the setting in music therapy gives a patient room to express his symptoms.

In music therapy the symptoms experienced by the patient can be “performed” and can be turned into music. In music therapy there are no taboos; even psychotic symptoms such as hearing voices can be expressed. In this way the patient can create distance from his pain and anxiety, in a safe setting together with the music therapist. The symptoms can be played, can be performed, and maybe transformed.

AMBIVALENCE, BLACK/ WHITE THINKING

In order to work on the schizophrenic patient’s tendency to be ambivalent, and think in black and white, I use a method I call “the principle of polarisation”. This is inspired by, among others, Priestley’s Splitting technique, (Priestley 1994) gestalttherapy (Perls, F.S 1984) and psychodrama.(Moreno 1999)

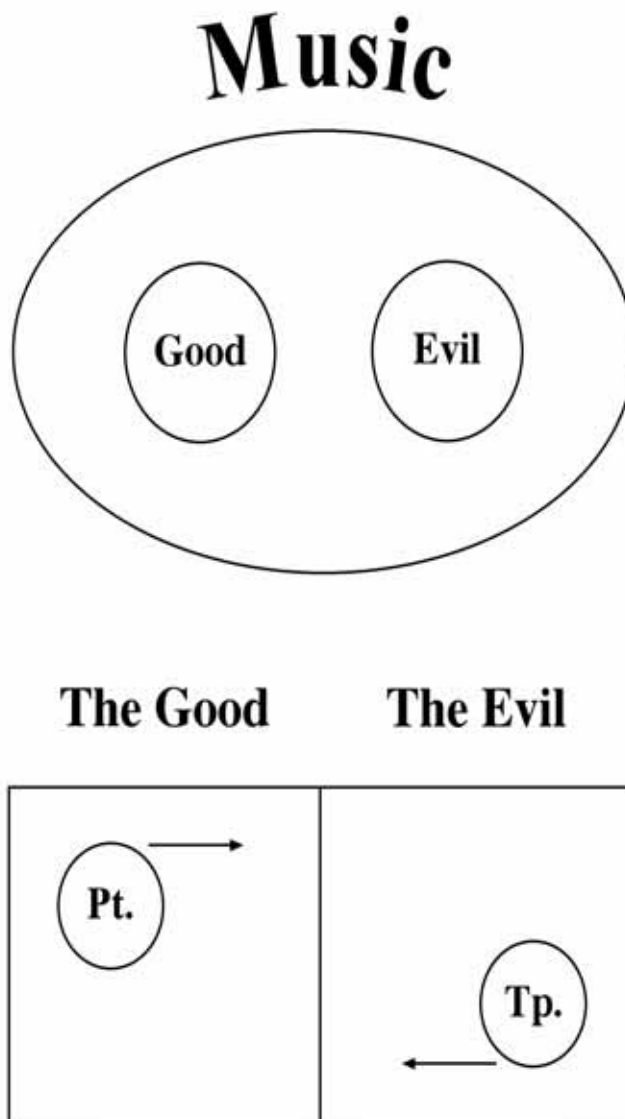
The aim is to create an integration between polarities. For many psychiatric patients it is often difficult to contain opposite feelings. The patient creates a split between for example the “good” and the “bad”.

When patients only stay in one polarity, i.e. the feeling of being evil, the other pole “good” will be externalised and the two poles will stay rigidly separated. There is much energy involved in keeping the sides in the split strictly separated.

In music therapy I can let patients **explore** the opposite pole. In the music the poles can be present at the same time, in the same improvisation. (see figure 2)

A technique I often use is to very concretely divide the music therapy room into two parts. The one side of the room represents the one pole i.e the good ,and the other side represents the other pole i.e. the evil. The patient can then move freely between the two sides. In this way the separation between the two poles can become less rigid.

FIGURE 5.



Another method is to make 3 continuing improvisations: If a patient is sad for example, I can suggest that we first play an improvisation where he expresses sadness. In the next improvisation he expresses the opposite pole, joy. Then we make a third improvisation where both poles are represented,

or the patient chooses to express one side of the polarity in the improvisation and I play the other side. Then there will be integration, because both sides of the polarity are expressed in the music at the same time.

Full integration is of course not possible for a schizophrenic person despite these techniques. It is extremely difficult for a schizophrenic patient to integrate opposite poles. What I can do in music therapy is to let the polarities communicate, interchange, and in this way lessen the gap between them.

INTENTIONALITY

In the act of creating music, schizophrenic patients can experience that they themselves are the origin of their own actions. For example, Chr did not hear voices while playing music, because "I get into it, to do it as well as possible...it's our story" Playing is a focussed social activity, that can take place in the music therapy room but also can be expanded to the community, ie. by producing CDs, doing performances etc.

IDENTITY

The different techniques described above can contribute to strengthening the identity of the patient.

At the same time, the schizophrenic patient's identity will always be very vulnerable. The weakening identity is manifested in problems with integrating opposite polarities.

I will return to the case: Christian has great difficulties in integrating polarities. In the discussion of why Christian quit the band, I identified the following polarities as relevant: health/ sickness, power/powerlessness, and structure/improvisation. These I will reflect upon in the following.

HEALTH/SICKNESS

In the band, Chr may have experienced the polarity between health and sickness as more obvious and amplified because there is a healthy person who does not take a supporting role in relation to him. He has joined the band because he wants to play music.

Christian has tried to take the healthy role, supported by me. And he has really improved. He now dares to go out into the world by bicycle or bus. And he has had dreams about recording contracts and gigs. For a certain period of time he can maintain this, but when he cannot do it any longer he switches back to the opposite pole, he takes the sick role again. He is still schizophrenic, so it is difficult for him to integrate the healthy and the sick sides. And if I am not aware of this, there is actually a big risk that he will get really psychotic. If he had been able to make an integration, he might think “I have ambitions for the band but at the same time I must take into consideration that I am sick.”

POWER/POWERLESSNESS

The singer is in the front of the band. He brings many songs and he even begins to play electric guitar. This may be threatening to Chr., who then withdraws, instead of fighting for his place. In the latest phases of the therapy I have chosen a more withdrawn position, because I think the time has come where they can manage alone, which may also be threatening to Christian and anxiety-provoking.

STRUCTURE/IMPROVISATION

Another important polarity is structure/improvisation and product/ process. To Christian improvised music is very important. He has persistently argued for having improvisations integrated in the compositions and complains that there is no time for improvising and jam because they are so keen on producing new songs in the band. The balance between structure and improvisation has been displaced.

Can presenting case studies influence the therapy?

The case with Christian is a case I have often used in presentations (in 3 conferences for music therapists, one radio programme, 1 newspaper article, 2 articles, 9 workshops and 6 presentations for staff.) And during the last year I have considered using him as case material for the conference in Finland. Christian has been very conscious of this. I find it interesting to reflect on whether this has influenced his quitting the project.

Christian has turned into a project for me, and that has seduced and blinded me not to see danger signs. I have also been seduced by his improvement and his healthy sides, and overlooked that he is still a vulnerable schizophrenic person.

I find it very difficult to determine whether there are ethical problems in using patients as case material meant for presentations. In Christian's case, he actually likes very much to be part of my "show". It seems to stabilise his identity. But on the other hand it is not a persistent identity because it is dependent on me being able to use him as "material". And it is demanding to live up to being someone's project.

Interview with Christian

The last perspective is Christian's explanation of why he wanted to quit the project.

He thinks that he can not live up to the success because he is sick. He says:

"If I continue I won't be able to take it. What if we get a recording contract, where other people will think, great. I think about us having to play a lot of concerts – that would be really hard for me. I'm sick, I can't manage. So many people have broken down by playing music; think about Jimmy Hendrix and Jim Morrison. I'm afraid of ending there. "

Christian has tried to maintain the healthy role, and has now switched back to the sick role. But during this long process he has been in contact with both poles. The music band has not been in vain. He has experienced both polarities and is no longer rigidly stuck in only one. I think it is better to change between the two poles than constantly staying with one of them.

He also says:

" But I have also changed a little. The music is still important, but to be together with the canary "Hendrix", and see how he flies around chirping, that is also very fun. There are other things in life than music that attract me."

In a way this is a rather healthy attitude. It is not only a passive withdrawal that he quits the project. He makes a decision. He needs a pause. He acts. And it is very important to him to terminate the project in a proper manner when he is ready for it. He expresses it in this way: " I want to make a CD no. 2. That will be my final project. Then we end in a good way with no hard feelings."

NEW INDIVIDUAL THERAPY SESSIONS

After he has stopped with the band he continues individual therapy. In these sessions it is obvious that he needs to be 'seen' by me. And he enjoys improvising.

When I ask him what the music expresses he says: hope, future, concentration, connection. And he says after our last improvisation here a week ago: I felt freedom. It was nice. That was just what I needed.

Coda

I will end my presentation with some videocuts from our last 3 individual sessions after he left the band.

When we play a very “crazy” improvisation a member of the staff interrupts the therapy. She says “what kind of crazy music is that?” You can see how his body language changes. Immediately he turns to the camera, maybe conscious of later viewers, and he plays some conventional chords on the guitar. Even though we are having a very exciting mutual musical dialogue that we both enjoy, a disturbance from a ‘normal’ person affects him deeply.

VIDEO

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*”Significant moments”
in music therapy with
young persons suffering
from Anorexia Nervosa*

Trondalen, Gro

Keynote 6 on Saturday morning, June
19th 2004, 09:00-09:45

KEYWORDS:

significant moments, anorexia nervosa, improvisation,
phenomenology

INTRODUCTION

Julie, a woman of 25 years, suffering from Anorexia Nervosa (AN) said before leaving her 3rd individual music therapy session:

It is strange ... during these two weeks I feel I have known you for a long time ... everything is opening without doing anything to make it happen.

I believe such a comment is related to both musical and interpersonal aspects, which is connected to other dimensions than only the verbal and semantic perspectives.

In musical improvisation I have often experienced a condensed awareness and a “heightened state of arousal”, during the playing. After such relating experiences through music there have been some seconds of silence, a smile or shyness where we both know we have been close to each other. So far, I have called these relational experiences through music “golden moments” (Trondalen, 1997). I came a bit closer to this phenomenon: “something more than interpretation” in music therapy when I heard Daniel Stern’s presentation on “hot present moments” (1996) eight years ago. Stern put focus into *the implicit relational knowing* when he addressed the question of how people change in psychotherapy through non-verbal means.

Throughout the years I have constantly become more curious about this “moment-phenomenon” and its relevance to music therapy. This “devoted searching” led to a Ph.D. research named *Vibrant Interplay*, with the subtitle *A music therapy study of “Significant moments” in musical interplay with young persons suffering from Anorexia Nervosa* (Trondalen, 2004).

Vibrant Interplay is about moving musically together - in time. It includes the music and two free individual “birds” i.e. the client and the therapist. These two persons have different personalities and different roles in music therapy, but are completely equal as human beings.

This keynote presentation is based on my Ph.D. research and is divided into different parts: I) Focus - including sub-questions II) The research project III) The research methodology IV) The theoretical basis V) The clinical music therapy approach VI) The analysis of the empirical data VII) The findings VII) Implications and further research before IX) Closing comments.

FOCUS

There are especially two aspects leading to the focus on Significant Moments in music therapy with people suffering from eating disorder. Firstly, I have already mentioned my curiosity about *moments* in relation to Implicit relational knowing. Secondly, within a very short period of time I got many enquiries from parents, who were in despair because of their adolescent girls suffering from eating disorders. Parents told me that their young adults were so “tired” of going to psychologists or psychiatrists and “just talk”. The adolescents wanted to *do* something instead of using words all the time. In Norway only very few music therapists worked with this group of clients. Accordingly, there was a growing need for a clinical music therapy practice offered to people suffering from eating disorders and consequently a need for research within this area.

On this basis emerged the focus: *How can musical interplay frame “Significant Moments” for young persons suffering from Anorexia Nervosa?*

The focus was elaborated through the sub-questions:

6. What do “Significant Moments” signify in musical interplay?
7. How can “Significant Moments” in musical interplay support a subjective experience of emotional connectedness to oneself and others?
8. How can “Significant Moments” support personal development and growth?

So far, I have been talking about moment as a concept. But how do I understand moment from my point of view? I would like to use a metaphor borrowed from the phenomenologist Husserl, relating to his way of thinking about the duration of a moment.

Husserl is offering the concepts of “retension” and “protension” as a pair of terms to describe the inner flow of time when listening to a melody. He uses the metaphor of a comet travelling through space. The glistening tail of the comet represents past notes of the melody that have been retained in immediate memory. The present is represented by the head of the comet, and the trajectory or “projectory” of the comet is analogous to “protending” or predicting where the melody might lead or be developed. During any “now” instant or point in a melody, notes heard earlier are retained in consciousness while one anticipates further development and closure.⁶ (Ferrara, In press, p.27).

Accordingly, a *moment* in this study is not defined as a certain amount of seconds or microseconds before the analysis takes place but is connected to the subjective

experience of time i.e. *kairos*⁷. From this follows that a moment is seen as the head of the comet i.e. the moment is limited but influenced both by the past and a possible future⁸. Accordingly, a moment is a term which describes “duration in time”.

I have also chosen the term *Significant Moments*. Significant is derived from Latin “significare”, which means, “give clear sign”. The term Significant is the present participle, which implies participating in the here-and-now (Aschehoug and Gyl-dendal 1991).

Hence, a “*Significant Moment*” is a term that signifies some clear and evident signs in a limited period of time which is analysed and contextualised.

The research project

The *implementation* of the research project meant co-operation with a psychiatrist, who was responsible for the clients from a medical point of view. The clients were offered outpatient individual music therapy.

The *data collection* lasted for one year. The clients knew they participated in a research project and gave “informed consent” (Hammersley & Atkinson, 1996).

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6. Thus, for the Husserlian phenomenologist, the manner in which sound occurs in time is of great importance in music analysis. One does not hear a melody as successive, dislocated notes but as a whole melody that is being constituted by consciousness in time. As one progresses through a melody (or work), protentions (future notes or phrases) become less and less protensive, then become present as “now” points and finally recede into the past. Perhaps most important is that during this entire experience of musical time, one experiences a melody (and an entire work) as one enduring whole.” (Ferrara, In press, p.27f.).
 7. There are two terms connected to the experience of time. The first is *chronos*, which is objective time i.e. the passage of time is linear, and its measurement is in physical units. The second term is *kairos*, which is connected to subjective time. This notion is personal i.e. time is psychologically perceived and connected to the person as an organism (Aldridge, 1996, p.37).
 8. A short time ago I read Daniel Stern’s latest book *The Present Moment in Psychotherapy and Everyday Life*, which is recently published. I found Stern is also referring to Husserl and phenomenology, when using the comet as a metaphor to describe the duration of the subjective experience of a present moment (Stern, 2004, p.27).

The data collection was carried out in a “natural setting” (Bruscia, 1995a, p.71), which meant the clients had music therapy as usual without being asked to perform anything special on my request.

The *data-resources* included primary data such as minidisk recordings of all the sessions, the clients’ spontaneous comments and a semi-structured interview after the music therapy process had been closed. In addition I wrote a logbook and made reflexive notes after every session. Then came the secondary data, which included transcriptions from all the sessions i.e. both verbal- and musical interactions. The music was then written into a score. As a supplement I also had the comments from the clinical and the scientific supervisors during the research process. At last came the tertiary level, which included the analysis and the meta-discussion connected to theory and philosophy.

The *selection of clients* in the study was based on practical reasons and included both similarities and differences between the two persons who were chosen. In brief, Julie 25 years (AN/Restricted type) and Simen 19 y (AN/Bulimic type):

1. A woman and a man
2. Both with AN (female: Restricted type, male: Bulimic type)
3. One long (13:43) and one short (2:46) improvisation
4. Both had a worsening of their AN during a stay abroad
5. Both participated for one year (The therapy closed due to practical reasons in the clients’ lives)
6. Both came from cities, but from different places in Norway
7. Female: trained piano player, Male: never played any music instruments before
8. Male: 19 sessions, Female: 10 sessions within one year

Both the client and the music therapist pointed out the *improvisations*, which were used in the analyses, as important.

The *identification of the “Significant Moments”* was done by triangulation (Bruscia, 1995c, p.318). A scientific supervisor, a peer music therapist and I listened to the music, each indicating when “something” was happening before explaining in text what was heard. The place where the markings from the three persons matched, I called “Significant Moments”.

The research methodology

The design is qualitative oriented (Bruscia, 1995b; Robson, 1993/2002). The study may be termed eclectic including both hermeneutical and phenomenological perspectives (Alvesson & Sköldberg, 1994; Polkinghorne, 1989), while the analysis is a phenomenologically inspired procedure for data-analysis (Ferrara, 1984).

The *clinical theory* is based on developmentally informed psychology (i.e. infant research) (Bråten, 1998; Stern, 1985/2000; Trevarthen, 1999).

In the study I am both a *music therapist* and a *researcher*: “a participating observer” (Robson, 1993/2002, s.189), which is a most wonderful and challenging position.

In the *analysis of data* I wanted to focus on both the music and the interpersonal dialogue. The methodology for the analysis of data developed like a lily: slowly and gradually unfolding itself in its subjective time⁹. Already in the 1980ies I had become familiar with Ferrara’s article where he presented a phenomenological procedure for music analysis (1984). Later on, I was inspired by his book where he elaborated upon the procedure (Ferrara, 1991). Other music therapists have also been inspired by Ferrara (e.g. Ruud, 1987; Amir, 1990; Forinash, 1989; Forinash & Gonzales, 1989; Grocke, 1999; Skewes, 2001; Arnason, 2002;). But I had to find my own way, which turned out like this:

A PHENOMENOLOGICALLY INSPIRED PROCEDURE FOR DATA ANALYSIS
(Trondalen, 2003, 2004)¹⁰

1. Contextual step

At the contextual step importance is attached to the client’s *personal, social, biological, musical* and *clinical* history. The last-mentioned implies a focus on the client’s history of treatment including dating the particular improvisation within the music therapy process.

2. Open listening

9. During this “unfolding” period I received a postcard, which inspired me a lot. The card showed different stages of an unfolding lily; from butting to blooming. I received this “gift” from one of my former clients suffering from Anorexia Nervosa, telling me she was “also” unfolding - at her own pace.

10. Steps 3-6 focus on the Significant Moments.

a.) Listening to the whole improvisation many times to focus on the improvisation *as one enduring whole*.

b.) *Body listening* (i.e. moving to the music) is done by the researcher to take care of the bodily aspect in the analysis, which is of special importance when working with clients with AN.

3. Structural step¹¹

a.) Sound/intensity *experienced* in time is written into an intensity profile. Intensity is understood as a form of level of activity (e.g. arousal).

b.) Sound/music *measured* in time. This part concentrates on a structural analysis of the music (SMMA¹²) and is illustrated by a score. The most important, however, is to identify musical relationship and cultural codes between client and therapist at a structural level.

4. Semantic step

a.) The first part is to look at - and describe musical structures in relation to other information e.g. comments, gestures and verbal metaphors. Through this procedure it may be possible to say what the music means or refers to (Cf. Referential – explicit meaning).

b.) The second part focuses on codes and symbols in the music and may add meaning to the musical interplay between the client and therapist. On such a basis, the music may be seen as a metaphor for being in the world (Cf. Analogy - implicit meaning).

5. Pragmatic step

The most important thing here is to give attention to a potential effect or outcome of the improvisation in the music therapy process.

6. Phenomenological horizontalisation

This step includes listing up important issues, musical cues and events. In such a horizontalisation all elements should be given equal status.

7. Open listening (cf. step 2)

a.) Listening to the whole improvisation many times to focus on the improvisation *as one enduring whole*.

11. The term structure is used in a generic way.

12. This SMMA is a variation of Grocke's Structural Model of Music Analysis (1999) and includes Dissonance/consonance, Dynamics, Texture (horizontal/vertical), Harmonic content, Instruments, Intensity, Intervals, Chromatics/tonal features, Melody, Rhythmic features, Mood, Style and form, Structural form, Tempo, Key, Pitch range and Duration/time.

b.) Body listening (i.e. moving to the music) is done by the researcher to take care of the bodily aspect in the analysis.

8. Phenomenological matrix

This step consists of a descriptive summary including a) the *music* b) a *potential meaning* of the music and c) a *possible effect* of the improvisation within the treatment process of music therapy.

9. Meta-discussion

The meta-discussion takes into consideration the phenomenological matrix, the client's comments and behaviour, the semi-structured interview with the client, the therapist's self-reflexive notes in addition to theoretical and philosophical aspects.

The theoretical basis

MUSIC

The term music includes both proto-musicality (Trevarthen, 1999) and music interpreted in culture (Ruud, 1998). My philosophical approach implies that the human consciousness always intends or directs its awareness towards things in time (Polkinghorne, 1989; Sokolowski, 1974/89). This includes a "generic view" of musical interplay and a need for contextualisation when it comes to interpretation of the different phenomena.

ANOREXIA NERVOSA

There are two subgroups of Anorexia Nervosa: a Bulimic (B) and a Restricted (R) type. A bulimic type means that the person repeatedly has episodes of binge eating before vomiting, while the restrictive one occurs without bingeing and vomiting (Skårderud, 2000).

Further, I would like to draw attention to some psychopathological aspects of Anorexia Nervosa according to the literature. One of the most striking features is the *embodiment*, which means (Duesund & Skårderud, 2003, p.7):

... body and food are *primary*; for the patient's attention. At the same time, the body is *secondary*; secondary because the anorectic embodiment is a medium. The body is used as an external, concrete tool for promoting the internal life. The body is used in psychological and social manoeuvres for the promotion of self-esteem. We can describe this as an instrumentalization of the body.

Inner symptoms include low self-esteem (e.g. shame with its various masks, Skårderud, 2003), ambivalence and the need for control i.e. problems with self-regulation (Goodsitt, 1997). Another feature often mentioned is alexithymia, which simply spoken means “lack” of words for feelings, a “lack” of connection between soma and psyche and difficulties with symbolizing (Cochrane, Brewerton, Wilson, & Hodges, 1993).

In music therapy this psychopathology is often reflected in a rigid or stiffened playing, hardly any development in the melody, lack of structure or too tight rhythmic structures (i.e. lack of flexibility), no spaces in the music, or a musical playing out of control, according to Robarts (1995; 2000). The latter aspect may be explained with a borrowed metaphor from Britta Vinkler Frederiksen; “losing balance when running down a hill” (1999, p.220).

MUSIC THERAPY, MOMENTS & ANOREXIA NERVOSA

When I searched for literature about eating disorder *and* music therapy I hardly found anything published before the end of the 1980ies. In 1989 the German Music Therapy Journal *Musiktherapeutische Umschau* offered two special issues on Eating Disorders (1989a; 1989b) and since that time the amount of literature has slowly increased (e.g. Nolan, 1989; Parente, 1989a; 1989b; Tarr-Krüger, 1991; Justice, 1994; Loos, 1994; Robarts, 1995; Rogers, 1995; Sloboda, 1995; Frank-Schwebel, 2001; Loth, 2002; Trondalen, 2003). Most literature was related to individual treatment in *institutional settings*, with least attention to groups.

When I searched for *moments* in therapy, I found a lot more published literature. Among these are *Turning point* (Böhm, 1992), *Turning point and Intersubjectivity* (Natterson, 1993), *Goda ögonblick* (Olsson, 2002), *Vändpunkter* (Carlberg, 1996), *Vendepunkter* (Johnsen, 1995; Aarre, 2002), *Betydningsfulle hendelser og Signifikante hendelser* (Johns, 1996; Johns, 1997), *Peak experiences* (Maslow, 1962; Nordoff & Robbins, 1977), *Pivotal moments* (Grocke, 1999), *Varme øyeblikk* (Ruud, 2001), *Gode øyeblikk* (Aasgaard, 1996a; 1996b), *Meaningful moments* (Amir, 1992), *Meningsfulle øyeblikk* (Oveland, 1998), *Moment of Meeting* (Stern, 1998; Stern et al., 1998) and *Nodal Moments* (Harrison, 1998).

From a methodological point of view, I found Grocke’s study (1999) to be most relevant to me, even though her study was in the receptive music therapy method The Bonny Method of Guided Imagery and Music. The reason for this relevance was her *phenomenological approach* where she did analysis of both *words* and *music*.

When I searched for *moments*, *music therapy* and *eating disorders*, I did not find anything.

CLINICAL THEORY

My theoretical music therapy approach resonates with developmentally informed psychology. Such an underlying philosophy includes a shift from an intra-psychic to an inter-psychic perspective within an intersubjective matrix (Bråten, 1998; Stern, 1985/2000; Trevarthen, 1980).

This theoretical approach also makes a shift from a stage model to a layered model of development. Core elements are the child's experience of senses of self in relation to itself and in relation to other people. These inner experiences of senses of self organise the child's development (Stern, 1985/2000).

Transferred to *musical improvisation* I would like to focus on the "moving along process" in musical interplay, which includes two consecutive goals. One goal is to explore the theme of the improvisation, including both musical and interpersonal gestures being played out. The other one is to participate in *the moving along* process itself.

There *are* two kinds of representational processes involved in such a theoretical thinking. One kind of representation is the *Explicit Knowledge*, which is semantic representation: symbolic, verbalizable, declarative, possible to be narrated and reflectively conscious.

The second kind is the Implicit Knowledge, procedural representation, which is non-verbal, non-symbolic and unconscious in the sense of not being reflectively conscious (Stern, 2004, p.113). This implicit knowledge is rule-based representation of how to proceed; how to do things. However, these procedural representations consist of two kinds of representational processes. One is the Implicit generalized knowing, which is representation of how to proceed e.g. how to ride a bike. The other one is the domain of *how to do things with intimate others*, including affective, interactive and cognitive aspects (Lyons-Ruth, 1998). The latter domain is the most important perspective for me to explore in this presentation.

In this process of how to do things with intimate other, I think musical interplay is a most powerful way of practising and recognising regulation. The theoretical understanding of the term regulation is rooted in Tronick's *Mutual Regulation Model* (1989). This model describes a micro-regulatory social-emotional process where interactive "errors" turn into (or fail to turn into) interactive repairs. Transferred to music, such a philosophy opens for exploring the dialogue between the client and the therapist through *musical* elements and gestures. Accordingly, failures in the music can be redefined as information maintaining the interaction, preventing repetition of negative interactions.

RIG is short for **R**epresentation of **I**nteraction being **G**eneralized. This means how earlier experiences of interplay influence later interactions and by repetition make inner generalized representations. The Proto-narrative envelope is a goal-directed unit, which may contribute to predict and understand human activity. It has a narrative like structure, namely a proto-plot, an action, an instrumentality, a goal and a context. It is a time envelope as well as an event envelope. Stern sees this phenomenon as “an emotional narrative that is felt rather than as a cognitive constructed story that is verbalized” (2004, p.58). On this basis he has now changed the name from Proto-narrative envelopes to Lived story. In my theoretical approach to “Significant Moments” I was occupied with phenomena named *RIGs* and *Proto-narrative envelopes* (Stern, 1985/2000; 1992; 1995). *RIGs* and Proto-narrative envelopes deal with how experiences are represented and how a person develops a coherent representation of himself. They are about interactive experiences with someone, while fantasies and imagery elaborations and additions are seen as later reworkings (Stern, 1995).

RIGs and Proto-narrative envelopes are analogous phenomena. The difference between the two is that the Proto-narrative envelope / Lived story is “conceptualized from an assumed subjective point of view of the infant in the interaction, while *RIG* is identified mainly from the adult’s objective point of view, observing the interaction from the outside.” (Stern, 1995, p.94).

The clinical music therapy approach

The clinical music therapy approach included free improvisation, usually without any pre-selected improvisation-themes, followed by a verbal dialogue after the improvisation had been performed. Sometimes the client and the therapist listened to the recorded music immediately after the improvisation (“self-listening”) but not always. In every session the client chose the instruments himself and the therapist adapted her instrumental choice to the client’s preferred instruments. From out of this “musical moving along process” emerged melodies, harmonies, chords, singing etc. Before leaving the session the client was asked to write a word, a sentence or a small drawing to conclude the session, i.e. a “summing up”.

Examples of such “summing up” are e.g. “energy through improvisation”, “a possibility of peace in mind”, “I am happy – but I hope I am not going to jump that much up and down from joy that I lose even more weight”. Another one is “percussion demands concentration; concentration is getting better”. One can imagine how hard

it is to concentrate when one has decided that the daily ration of food is only half a slice of bread.

The empirical data

EXAMPLE I: “SELF-LISTENING”

*Julie, a woman of 25 suffering from AN/R for the last 5 years, rushes into the music therapy room. She lives an extremely “turbo-life” and does not eat unless she really feels she earns it, she says. This session she appears extremely upset and distressed. Julie is offered to listen to an improvisation from her previous music therapy session through earphones, while wrapping herself in rugs. During the “self-listening” experience¹³, Julie apparently moves from “chaos to order” within less than three minutes. It seems as if she is being connected - through music. *Julie is a piano-player but in this session she is singing while playing an African drum. The music therapist plays the piano.**

Immediately after the “self-listening” experience Julie says:

It is as if an empty space is filled inside of me ... memories are coming forward ... I am a bigger part of the music when I’ve made it myself ... this really gives me something ... the finest part was the last part where you played the piano and I sung and played the drum, which I never do. It was that combination that contributed the most to a sort of ... quietness and peace... It is strange ... it is as if everything is opening without doing anything for it.

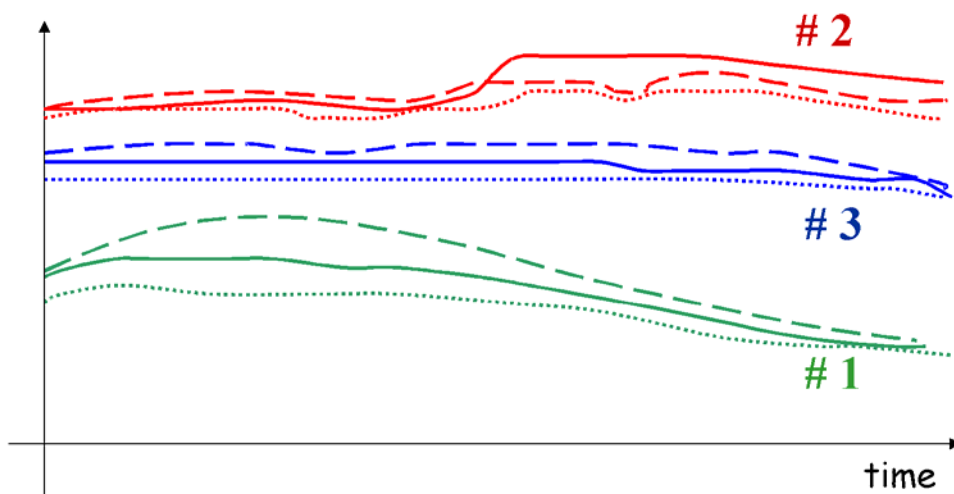
The musical improvisation was performed in the 2nd session out of ten. Julie did her “self-listening” experience in the 3rd session. Bruscia (1998, p.125) defines “self-listening” as a variation of receptive music therapy: “The client listens to a recording of his/her own improvisation, performance, or composition, to reflect upon oneself and the experience”.

This particular improvisation lasted for 2 minutes and 46 seconds. Three “Significant Moments” were marked during the triangulation. These were: #1 from 0:55-1:04 (9 seconds, 4 bars), #2 from 1:10-1:35 (15 seconds, 8 bars) and #3 from 1:43-1:51 (8 seconds, 4 bars).

13. For an elaboration of the “self-listening” experience see Trondalen, 2003.

According to the analysis procedure, I made intensity profiles of the triangulated Significant Moments. Then I put all the intensity profiles on top of each other. Interestingly, I found that the therapist most of the time had a lower intensity than the client within these Significant Moments. This is different from e.g. when a mother is interacting with her infant. I think this an interesting finding from a clinical point of view when working with people suffering from anorexia. I believe this phenomenon is related to the importance of letting the client be able to *control* to avoid the feeling of being pushed or overwhelmed. This attitude is similar to Fredriksen's considerations in her article about *Resistance in a Client with Anorexia Nervosa* (1999).

FIGURE 6. Intensity Profiles "Significant moment" Improvisation I.



Figur 1. Intensity profiles "Significant Moments".
Improvisation I.

(green) #1 (red) # 2 (blue) # 3
(---) vocal:client (-) piano:music therapist (...) African drum:client

The improvisation was also written into a score. What was evident in the score was the development of syncopational shifts against the steady pulse within the “Significant Moments”. This point is similar to Grocke’s study of pivotal moments in *The Bonny Method of Guided Imagery and Music* (1999). In the first moment, the client syncopated vocally, the second she syncopated both vocally and in the drum playing. In the third moment, all the instruments made syncopational shifts against each other (vocal, drum and piano).

FIGURE 7. “Significant moment” # 3. Improvisation I.

The image shows a handwritten musical score for three instruments: Piano (Pno.), Vocal (Voc.), and Drum (Dr.). The score is written on three staves. The Piano staff is in treble clef with a key signature of one flat (Bb) and a time signature of 4/4. It features a steady pulse of eighth notes in the right hand and a steady pulse of eighth notes in the left hand. The Vocal staff is in treble clef with a key signature of one flat (Bb) and a time signature of 4/4. It features a melodic line with syncopation. The Drum staff is in treble clef with a key signature of one flat (Bb) and a time signature of 4/4. It features a steady pulse of eighth notes. The score is marked with '1:45' and '1:51' at the top. The Piano staff has a '46' at the beginning. The Vocal staff has a '46' at the beginning. The Drum staff has '46', '47', '48', and '49' at the beginning of its measures. The dynamic 'mf' is written above the Drum staff. The score is handwritten and appears to be a sketch or a working draft.

Phenomenological matrix: Improvisation I. In the *music* the rhythm develops through acceleration and /or syncopational shifts against the steady pulse. The structure and harmonic progression are predictable (Dm-C-Bb-A7) and the dynamic is intense and condensed. Melodic lines are progressing by rising and fall-

ing. The piano is performing a repetitive form and contains a clear rhythmic grounding in the events.

I find similar use of a musical structure with steady rhythmic beat and melodic lines on the top in a case study with a woman with Anorexia Nervosa written by Neugebauer, Gustorff, Mathiessen and Aldridge (1989). Among other aspects, the authors suggest the use of an "Organum-akkord" ("organum-cord") to support melodic and rhythmical exploration. I suggest such an Organum-akkord to be similar to the use of the repetitive Spanish mode in Julie's improvisation.

A phenomenological reduction of the *meaning* may be that the solo voice creates the illusion of seeking towards control and controlled retreat. The piano has a containing function but at the same time initiating and energising. The soloist takes time and space to "spread out", in other words, showing herself.

The *effect* of the musical improvisation within the treatment process may be that the client feels recognised, while experiencing a development of the interpersonal relationship. She seems to be able to benefit from the music to "fill" her emptiness, bear her ambivalence and promote "peace in mind". It seems that the musical experience supported an experience of being connected in time and space.

In the research *Vibrante Interplay* (Trondalen, 2004) the "self-listening" experience was further discussed under the heading:

Connectedness in time and space. This theme was elaborated through a) Connectedness in the here-and-now b) Connectedness in the past and c) Connectedness in the future (see also Trondalen, 2003).

EXAMPLE II: AN ACTIVE IMPROVISATIONAL EXPERIENCE

Simen is 19 years old and has been suffering from AN/B for the last year. He has never improvised any music on his own before. Simen often seems restless, and his arms and legs appear to be "spread everywhere".

The client's improvisation is from the 17th session out of 19 altogether. Simen is performing the piano for the first time in his life. I am playing the percussion instruments. After the improvisation there are some seconds of "condensed awareness". I look at him, smile and say:

Th: And the exultation would never end?

Simen: No (laughter) Hoh!

Th: What happened during the improvisation?

Simen: I tried to find some notes – and sometimes it turned into small tunes

According to the triangulation, three “Significant Moments” were pointed out¹⁴. The 2nd and 3rd “Significant Moments” took place close to each other towards the end of the improvisation. The improvisation lasted for 13 minutes and 43 seconds. The “Significant Moments” were #1 from 4:51-5:25 (34 seconds), #2 from 11:36-12:23 (49 seconds) and #3 from 12:42-13:24 (44 seconds). It is interesting to notice that these “Significant Moments” are quite long, according to the triangulation. When I put *all the intensity profiles* of the “Significant Moments” on top of each other, it was also evident here that the therapist is usually playing below the client’s intensity within these moments, as in Improvisation I.

14. I do not have any good explanation why the triangulation showed three “Significant Moments” in both the analysed improvisations.

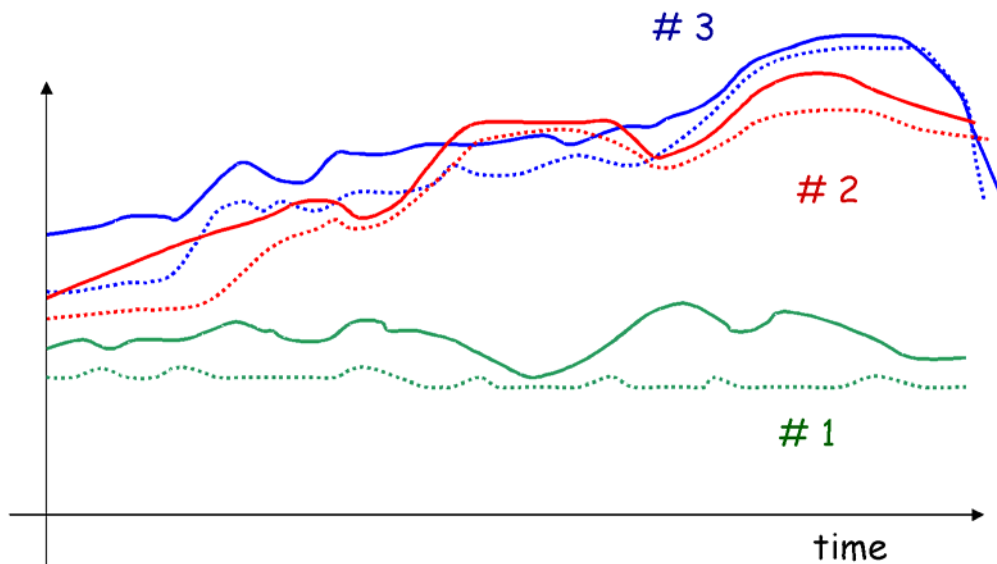
FIGURE 8. Intensity profiles “Significant Moments”. Improvisation II.

Figure 3. Intensity profiles “Significant Moments”.
Improvisation II.

(green) #1 (red) # 2 (blue) # 3

(-) piano:client (...) percussion:music therapist

In his daily life Simen really struggled to connect to himself and others. “I do not know – I do not know anything”, he very often said. But in the improvisation, it seemed as if Simen was able to connect to himself and the therapist through relational experiences through music.

In the closing interview Simen said:

I did never believe I would dare to try the piano ... but I did ... Music describes feelings. At least it does to me... Music is about movement, rhythm, strength and intensity.

The *score* of Improvisation II music was made into a graphic notation system due to the character of the music i.e. a very complex improvisation with lots of small details, which seemed to be “impossible” to fit into a traditional score.

Phenomenological matrix: Improvisation II. The structure of the *music* is characterized by limited melodic and rhythmical sequences in the piano. The one-note motive in the piano-playing is evident and the percussion instruments provide a steady basic rhythm throughout the improvisation. There is a mutual harmonizing of the intensity in the music.

The *meaning* of the music may be connected to both strength and sensibility at the same time. The one-note exploration contrasted with clusters in the piano may refer to emotional testing through music and contribute to self-assertion for the client.

A possible *effect* of the improvisation in the music therapy process may be that Simen has experienced to influence the musical relational experience himself without being overwhelmed by external forces or losing control. This may have led to a personal recognition of his ability to affect his own life through various modalities.

There were two central themes for the discussion part of example II (Trondalen, 2004):

1) *Senses of self* a) - versus another b) - with another and c) - versus and with another at the same time and 2)

Musical narratives of senses of self versus- and with - another at the same time .

“A LIVING BRIDGE”

Both Julie and Simen used their *living body* (Merleau-Ponty, 1964, 1989) to express themselves through music as opposed to an instrumentalization of the body (Due-sund & Skårderud, 2003). They moved rhythmically to the music, they used their body actively to play on instruments and Julie even sung. The performance of their *subjective body* seemed to promote vitality and the feeling of being alive (Trondalen, 2003).

I suggest these subjective inner experiences of being alive, “vitality affects” (Stern 1985/2003), occurred in parallel with the temporal contour of stimulation e.g. as shown in the intensity profiles. On this basis, I suggest that “Significant Moments” in relating experiences through music, followed by verbal discussion, provide a “living bridge” (a link) between soma and psyche for Simon and Julie.

The findings

One term turned out to be very important: *Regulation*.

I found that “Significant Moments” are sequences of regulation, which are mutually harmonized by the therapist and the client in the musical interplay.

Embedded in the term harmonization is affect attunement i.e. a form of selective and cross-modal imitation to share inner feeling states as opposed to direct imitation, which is a way to share overt behaviour (Stern, 1984).

The “Significant Moments” in musical interplay were *signified* by a) Melodic and rhythmical syncopational shifts against a steady/predictable pulse b) Intense and condensed dynamics c) Limited musical sequences varying in duration. In addition the moments appeared to be d) Positive with “condensed flow”. This point astonished me and is different from e.g. Grocke’s study (1999) where the “Pivotal Moments” also included moments of distress. Moreover, within the “Significant Moments”, these sequences of regulation, the client is e) actively “performing his life” together with the therapist.

Hence, I suggest the “Significant Moments”

a) to offer an exploration and softening of rigid and “stiffened” patterns of relating – leading to - new relating experiences through music.

This means b) that stored memories of feelings (RIG-s) can be affected and updated through musical interactive experiences and

c) may be termed sequences of Musical Proto-narrative envelopes i.e. Musical “Lived stories” (cf. Stern, 2004).

And that d) these sequences of Musical Proto-narrative envelopes (“Lived Stories”) make the basis for active contact with non-verbal senses of self during the verbal communication after the improvisations have been completed. I think it is of vital importance that both the therapist and the client have been actively involved in the interplay (i.e. new musical narratives have been created) and consequently e) that “Significant Moments” in musical interplay offer a link between soma and psyche (cf. alexithymia).

Implications

Based on this study, I would like to propose some implications focusing four dimensions.

The first dimension is *Clinical music therapy practice*. I suggest a music therapy approach includes both music *and* verbal dialogue for people suffering from Anorexia Nervosa. I believe the Musical Lived stories may be grasped in a broader sense when they are verbalised together with a therapist, who also has been actively involved in the improvisation.

The second aspect is related to some of the *theoretical aspects* presented on the pathology of people suffering from an Anorexia Nervosa. I suggest a "different" view of an anorectic person, hence, the anorectic person *is* able to regulate and harmonize herself through relating experiences of music. Cf. Simen's comment: "*When I leave music therapy I do not have to vomit the slice of bread I have in my stomach*".

The third dimension is connected to *Research methodology*. I think it is really important to include both interpersonal and musical processes in the data analysis instead of focusing only on one of the aspects. Such an approach also includes hermeneutical and phenomenological perspectives from a philosophical point of view¹⁵.

As further research studies, it would be relevant to look closer to the question: What happens *before* the "Significant Moments"? Another aspect of interest for me is to explore musical improvisation as "Dyadically Expanded States of Consciousness" (Tronick, 1998).

Closing comments

After the improvisation, Simen said that he had not tried to be clever but tried to do something he had not done before. He continued:

Simen: Sometimes I am afraid of trying all these new things.

Th: You can regulate everything at your own pace, you know.

15. For limitations of the study see Trondalen, 2004.

Simen: Yeah – I know.

Th: Yeah – and earlier you did not want to explore the piano at all.

Simen: No (Simen smiles and plays some notes at the piano) – but it so happened.

Vibrant Interplay gives hope, which I consider to be a main feature in the quality of life. Accordingly, development and growth are possible through mutual regulation in relating experiences through music.

The psychologist and researcher Aldridge offers some of his ideas about hope and creativity in this way (1996, p. 241):

Music therapy with its emphasis on personal contact and the value of the patient as a creative productive human being, has a significant role to play in the fostering of hope in the individual ... The opportunity offered by creative arts activities, for the patient to be remade anew in the moment, to assert identity which is aesthetic in the context of another person, separate yet abandoned, is an activity invested with that vital quality of hope...

Julie sung and played in music therapy and enjoyed it very much. During the music therapy process she tuned her piano at home and started to perform music, also when she had visiting friends.

In the closing interview with Simen I asked:

Th: Is there anything you would like to bring with you from music therapy?

Simen: Yes, it has been fun. And I am taking with me some concepts we have been exploring. I am aware of the link between the terms we have discussed in the verbal communication and what I have felt in the music.

Th: Here are two keywords you have written – and underlined - in the “summing up”. One is clarity and the other one is regulation.

Simen: Yes, I was also thinking about those words.

Th: What did you think about them?

Simen: (laughs) – I thought I would like to include them in my life.

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*The importance of music therapy for
encouraging latent potential in
developmentally challenged children*

Neugebauer, Lutz

Keynote 7 on Saturday morning,
June 19th 2004, 09:45-10:30

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How we look at children:

The work with developmentally challenged children is one important field of music therapy. Although widely recognized by parents, teachers and caregivers, we – as a profession – have still to struggle for recognition of our work with health and education authorities in terms of appropriate payment and cost refunding. To my knowledge this applies to most countries in Europe.

For this purpose we are trying to provide evidence of our endeavours in our publications, research projects and our daily work. The problem we face in doing so is that we begin to look at our own work from the view-point of those who ask us this question of evidence, or do we ourselves doubt that music has the capacity to foster, support and reach the children we work with? David Aldridge has described the given task in his book about music therapy in medicine: We have to learn to talk to the other health care professions, build bridges, as he calls it, and we have to bridge the gap between our own attitudes and beliefs and the attitudes and doubts and questions on the other side of the canyon. (Aldridge 1996)

If we place ourselves into a setting of the medical or health care professions it is very likely that we adopt the arguments that will be needed for the acceptance of treatment procedures according to the system of medical evidence as we find it for medical treatment.

This perspective lets us call our patients or clients, states a condition or problems, searches for the definition of therapeutic aims related to the diagnosis, and ideally has defined procedures or interventions related to a disease. A perspective that is related to a medical theory model which is explicit and acceptable to doctors, psychologists and those who authorize the spending of resources in the health care system.

Briefly said, this perspective looks at:

Patients from the view-point of a defined **diagnosis** that leads to **therapeutic aims** resulting in **interventions** and **defined procedures** and **strategies** which are accepted by **doctors, psychologists** and **representatives of the health care system**.

I do not argue that we should not think or work with these categories. We have to, and this is necessary on an existential level; but I would like to encourage you and myself not to forget the other perspective which we may choose, that of a “musician-therapist” who looks at – or rather listens to – people with their individual

potential of developmental opportunities in music and improvisation to serve the parental perspective of their child with his or her capacities and limitations, regardless of a medical condition or diagnosis.

TABLE 3.

| Patients | People |
|-----------------------|-----------------------------|
| Diagnosis | Potential |
| Therapeutic aims | Developmental opportunities |
| Interventions | Music |
| Procedures | Improvisation |
| Acceptance by | |
| Doctors/Psychologists | Parents/Children |
| health care | ourselves |
| objective | Artistic |
| state of development | process |

Ideally we will be able to bring both perspectives together in our work – we always try. The important question to me is, which perspective do we take to begin with in the work with the children or adults that we work with.

Diagnosis as on ongoing therapeutic process:

One of the premises of a treatment in a medical setting is that at the beginning of every treatment there has to be a proper diagnosis, this Greek word which means knowing (gnosis) through and through (dia).

So I would like to start with the postulation that we – for our work – need our own diagnosis, a way of generating knowledge, which looks for potential rather than for the lack, which looks at what children can do rather than what they can't. And here comes my limitation of language: I can only use the metaphor of looking at something closely, but what we do could be different and an additional information to the medical system: We can describe what we hear rather than emphasize what somebody else has already seen.

I am convinced that our profession has to offer a lot, if we look at – sorry: listen to - our work from this point of view. I am convinced that we contribute to a diagnostic knowledge in two ways.

- 1.** We might reinforce information that has already been generated, or
- 2.** We might add new aspects to a given diagnosis.

In both ways our own systematic evaluation will guide us in terms of therapeutic aims and proceeding.

To put my remarks into a practical framework I would like to introduce three children I have worked with. All three excerpts are from one the video-documentations of the first sessions and illustrate the diagnostic potential of improvised music in generating audible information as an objective source of diagnostic knowledge.

For the further proceeding I would like to ask you to only look at the excerpt and then continue reading.

PIET

FIGURE 9. (Video 1 - Piet)



This is Piet, he is aged 5, obviously handicapped, happy, strong-willed, holding sticks, playing by himself, he is listening attentively and enjoying the situation of making music with me and my team mate David Aldridge.

Piet is a child but threatened by death from the day he was born. Due to a rare genetic disposition, the Apert Syndrome, he had to undergo several major operations affecting skull, hands and feet. The first surgery was directly after his birth. Later, skin had to be transplanted to separate his fingers; his hands and fingers are all scars.

Due to this condition and its consequences Piet has not yet learned to walk, he does not have language, cries a lot and is reluctant to treatment of any sort, is afraid of hospitals and white coated people which he shows in outbursts of crying and screaming. His mother says he will not grasp anything as his hand are all sore.

When we report our observations and show the video she does not even want to tell us more about the medical background; she says she has never heard anything that positive about her boy.

No doubt, Piet is severely affected and limited by his handicap and yet music offers him an opportunity to show and detect a different side of himself. It is obvious that we will not be able to do anything about his medical diagnosis, yet we can help ourselves, himself and his parents to take a new perspective that looks beyond limitations and unfolds and supports his potentials.

GESA

FIGURE 10. (Video 2 - Gesa)



This is Gesa, she is six when she comes to this first session. She is affected by a cerebral palsy, quadriplegic.

We can see that she is both vocally and motorically active, aware of the situation and reactive.

When asked for their expectations of a treatment with music therapy the parents had said: “If only we knew whether she is aware of us...” An answer to this question was clearly given after these very first moments in music.

These examples show the possibility music therapy provides to come to a diagnosis, a knowledge that shines through what we can experience through our senses. Music offers – in my opinion – a unique approach to this knowing, as it offers a new perspective – a metaphor, which in itself is wrong – as we do not look at the children from a different angle: We have a big advantage in that we can listen to them.

As we approach children from a different angle it is not surprising that we hear things that are different from what other professions can observe. And this is the strength of our work:

Both limitations and potentials become clear and obvious.

Our diagnosis does not contradict what other people have found, it makes the diagnosis more complete.

It sometimes offers a discrepant perspective to the medical diagnosis, sometimes our impressions will support it. If we listen, look and describe carefully, we will not only be therapists, who fulfil a treatment task related to a condition of a particular child, we will then be able to contribute one part of a jigsaw puzzle to a more concise and clearer picture of this child’s possibilities.

Therapy

We can approach our therapeutic work from this same perspective, one that looks at the potentials:

I would like to describe another child: A boy who lies in his cradle all day long. He sleeps a lot. The only way for him to express his desires, needs and wishes is screaming or weeping. This also happens in the middle of the night. He cannot raise his head on his own, nor use his hands for a grasp. He cannot control his body, cannot find balance or focus his view. He has to be fed, and of course he is not toilet trained.

What a miserable condition, one might think; in fact it isn't, because this description was the description of my son at the age of three weeks. A perfectly normal baby, who grew up to become a perfectly normal teenager and sometimes makes me wonder which times were more exhausting.

What this example shows is the major point of this article: we look at children in terms of their potential and we rely on the fact that they themselves will develop to their potential. It is our task to create a stimulating, open, encouraging and welcoming environment which helps them to learn and find out.

I am convinced that this applies to normal average children as well as to those with individual and special needs or challenging conditions.

And again: As a music therapist I am convinced that we can offer something special: an open ear to the potential development.

LANGUAGE DEVELOPMENT

I would like to substantiate my conviction referring to language development as an example.

Normal children develop communication and language. They develop it in interaction and more: they will teach parents how to understand them, as it is their will to be understood. And parents understand and know intuitively what to do how to communicate. Many researchers have written about the musical quality of interaction and communication, among them Aldridge (1996), Trevarthan (2000), Stern (2000) and Papousek (1989).

Language development in children is one of the most important factors indicating "normal" or delayed development. All too often it is only a severe delay of language that alerts parents or doctors to a special situation in the development of a child. This seems surprising, as the development of language is well described in its relation to motor development and is – in this connection – part of every developmental description and parental guide. This link has been published well, since the possibility of photographic description of developmental stages was invented pretty early, and other fields of development have been linked to these "objective" parameters of observation. One of the pioneers in Germany was Prof. Hellbrügge (1976), so I refer to his developmental description of language and motor development. In his book "The first 365 days" he gives a detailed description of what a child in his normal development gains in terms of motor, social, communicative and language competences. Bringing this together in a table he was able to relate the various fields of development to each other.

For the further course of this article I have now taken language and motor development and will relate to them. In this article I will not go into detail of this developmental description as you will find them in many publications in different countries, much more easy to read if English is not your first language.

TABLE 4.

| Age in months | Motor and social development | Language development |
|---------------|------------------------------|----------------------------------|
| 1 | Reflexes focussing eyes | Screaming |
| 4 | Grasping | Vowels occur |
| | Social smile | |
| 6 | Playing with hands | squeaking |
| | Discriminating persons | |
| 10 | Sitting | Babbling |
| | Crawling | Two-syllable words |
| | Object permanence | |
| | Watching persons | |
| 12 | Standing | One-word sentences |
| | Walking | |
| 24 | Imitating | Two-word into complete sentences |
| | Playing with others | naming |
| | Eating with a spoon | |

One focus of my work in recent years was to relate these developmental descriptions to my competence, that of a musician. The focus of my question was: what musical elements can we hear in these developmental language progresses. This question is not trivial, as one of my clinical focuses has been the work with children who were developmentally challenged, and all too often this was connected with a delay in their language development. Very often parents would have the desire to communicate verbally with their children and not only talk to them but get a verbal response. In these situations parents would ask me as a music therapists what I think about their children and whether they will ever develop spoken language. I thought of my own children who seemed to learn language easily as they grew up, and I wondered what I could say to those parents to the best of my knowledge. As you know in the framework of Nordoff/Robbins (1977) Music therapy, which is the setting I have chosen for my professional work we describe all responses of chil-

dren in their musical quality. I have therefore asked myself, what are the musical qualities of what I hear as a progress in language development.

I then tried to work out these musical elements as they occur. For my presentation, which was then converted into this article, I asked young parents for video material showing language development of their kids. I have chosen three kids to illustrate the normal development of language and describe musically what we hear. The three children are special in their selection for this purpose as they have parents who talk to them in English, German and French.

In the first month (Figure 11 on page 665), when the child seemingly is motorically ruled by reflexes and tries to educate his parents to fulfil his basic needs what we hear is described as screaming. What we hear is phrases of vocalizing, in length and intensity highly dependent on the breathing of the child .

FIGURE 11. (Video 3 - Bathing)



At the next stage (Figure 12 on page 666), when the child is able to grasp and form vowels, we realize musically that the phrasing becomes structured deliberately or with an intention. The child leaves pauses as the parents do, and it is through these pauses that we interrelate socially.

FIGURE 12. (Video 4 - Ben1)



When the children grow older (Figure 13 on page 667), they begin to play with their hands and start to make more refined “spoken” sounds; in squeaking the children practice - musically spoken - the increase of their pitch variation and practice different timbres in their voice. At the same time in babbling we can see rhythmical structures emerging. This rhythm is most obvious in their language but virtually in everything they do.

FIGURE 13. (Video 5 - Claire1)



In their babbling, which occurs at the sitting and crawling age, or even clearer in two syllable words, children incorporate rhythmical structure (Figure 14 on page 668).

FIGURE 14. (Video 6 - Ben2)



The next basic musical element which occurs as a new step new is that of repetition. In repeating, the children become aware of themselves as an active music maker and sound producer. They relate their sound to the social situation (Figure 15 on page 669) and try to master the task to shape their music to the idea that they have. In repetition they obviously begin to practice.

FIGURE 15. (Video 7 - Claire2)



With standing (Figure 16 on page 670) and walking children begin to form two word sentences, and use language.

FIGURE 16. (Video 8 - Ben Lucca 1)



In these steps leading to language (Figure 17 on page 671), they bring together the rhythmical structures, melody and phrasing and shape them to an idea of a sound. They imitate, play with others and are able to eat with a spoon.

FIGURE 17. (Video 9 - Ben Lucca 2)



They have the ability of naming things (Figure 18 on page 672) and pick up new words or phrases. Musically spoken they are able to listen so carefully that they can repeat and reproduce - or rather reshape – what they hear with their own voice.

FIGURE 18. (Video 10 - Ben Lucca 3)



We can put those processes of musical development into the developmental table (Table 5 on page 672) that we used before and link our listening skills for a musical description.

TABLE 5.

| Age in months | Motor and social development | Language development | Musical aspect |
|---------------|--|----------------------|---|
| 1 | Reflexes focussing eyes | Screaming | Phrasing and pitch dependent on breathing pattern |
| 4 | Grasping Social smile | Vowels occur | Phrasing structured pauses |
| 6 | Playing with hands Discriminating persons | squeaking | Pitch variation Increased |

TABLE 5.

| | | | |
|----|---------------------|----------------------------------|--|
| 10 | Sitting | Babbling | Rhythmical structure and speech melody |
| | Crawling | Two-syllable words | |
| | Object permanence | | |
| | Watching persons | | |
| 12 | Standing | One-word sentences | repetition |
| | Walking | | |
| 24 | Imitating | Two-word into complete sentences | Rhythm melody and phrasing come together |
| | Playing with others | | |
| | Eating with a spoon | naming | |

The development of phrasing, rests, the possibilities to control pitch and sound as well as the ability to repeat and structure rhythms in time seem to be essential qualities of language acquisition. They can be described as musical qualities in musical terms.

They are therefore qualities we can work on in music therapy. And I would like to remind you of the title of this article: "encouraging the latent potential". Wherever we find this potential in listening to what the child does, the adventure is... what will happen next. And there is always a surprise. As with Anna:

Language development in music therapy

I meet her in a school for handicapped children; she is almost 12 then and has not yet developed language. She is diagnosed to be autistic and has tremendous difficulties to interact socially or play. She had MT in a group and individual sessions with a colleague before. When I saw her first she did all that:

FIGURE 19. (Video 11 - Anna 1)



Related to the potential she shows rhythmical and vocal activities, uses instruments to play and interacts in music. My improvisation picks up or offers musical context for the things she can do and she seems to enjoy and understand the situation.

We see her once a week for sessions of about 30 minutes. We have the opportunity to work with her in a pair of therapist and co-therapist, which is a great advantage.

Two weeks later a situation emerges that brings the musical focus to the aspects of leaving gaps and musical rests. It is in these rests where Anna becomes active, she seems to wait for her space, and in waiting activity, expectation and musical tension on my side a dialogue occurs.

FIGURE 20. (Video 12 - Anna 2)



Another leap in time of a few weeks. Anna begins to play – with help first, but only supported in grasping the sticks and helping her not to rock her body so intensely that she forgets about her playing. In this enthusiastic play she begins to sing, to reform what she hears and observes in my singing. This then develops to an operatic trio of Anna and both therapists at the end of the session. She manages to get hold of her capability to vary her voice, to control rhythm, melody and phrasing and make her voice a musical instrument for social interaction.

FIGURE 21. (Video 13 - Anna 3)



FIGURE 22. (Video 14 - Anna 4)



After the summer holidays and a rest in music therapy due to building works in the school we meet Anna (with a new hair cut) after an interval of almost three months. In a singing situation by the piano she shows us everything she has acquired and found for herself from these musical elements.

FIGURE 23. (Video15 - Anna 5)



I want to state clearly here: She has not learned to speak. What she has shown in music therapy is the ability of a latent potential. Music offers her the structure and security for interaction and use of her voice. It offers a supportive structure which helps her to use words to name things, persons or herself. Music in itself has this tremendous close connection to language development (Koelsch, S. 2005). Anna in her course of music therapy has gained profit from this close connection to the stage of using words.

For my own professional development and my work with children it has been very enlightening to look at the musical qualities inherent in language development – to listen with a musicians ear to how language occurs. This close look made me aware of little structures that children offer - structures to be picked up, expanded and taken on to encourage children to use the potential as much as possible for their own benefit.

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CHAPTER 3

*PAPERS OF THE 6TH
EUROPEAN MUSIC THERAPY
CONGRESS*

*Music psychotherapy for
torture survivors*

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Introduction

I have worked as a music therapist with torture survivors since 2001. In my work I have applied receptive techniques, which are based on music listening. In particular I have applied imagery processing with music that has been influenced by the Bonny Method of Guided Imagery and Music. Applied Guided Imagery and Music (GIM) has shown to be of particular benefit for severely traumatised clients. These clients were Vietnam veterans or sexually abused women who suffered from Post-Traumatic Stress Syndrome (PTSD). Symptoms of PTSD include angst, depression and obsessive-compulsive symptoms and clients may suffer repeatedly from flashbacks and intrusive thoughts and emotions. These are also part of the dissociative states that characterise PTSD. The psychopathology may vary from psychotic states to neurotic problems.

Earlier experiences of applied GIM with PTSD clients showed that it was possible to give clients hope and empowerment with music. It also helped them to relax and concentrate better and they were able to express their emotions and memories relating to their traumas more easily. It was reported that music therapy increased the self-understanding of clients and made it possible for them to connect their emotions to traumatic experiences. Applied GIM also lessened the hyperarousal and intrusive thoughts of clients. Music therapy gave the clients holistic pleasure and experience of cohesion in their mind and body and provided them with general sense of well-being. (Blake, 1994; Blake & Bishop, 1994.)

These kinds of positive experiences resulted in the idea of trying music therapy with torture survivors, who also suffered from similar and frequent PTSD symptoms. It also felt safe to start with something that had been tried before because there were not much knowledge, research and experience of music therapy with torture survivors at the time. It had been applied in Germany, The Netherlands and Denmark but there was not much existing literature and there is still not much at the present time. Research was also needed to investigate how music therapy could be a potential rehabilitation for torture survivors. Due to this and the need for evidence based medicine we also wanted to study music therapy with this client group. This idea developed into my doctoral research project "Music Psychotherapy of Torture Survivors" which studies clients' own experiences of music therapy, music and their rehabilitation. The phenomenological research started in 2002 and will be finished around 2006.

Torture as a Phenomenon

DEFINITION

Torture does not belong to human history but is currently happening in many countries. Torture is practised in almost half of the world's countries today. (Jacobsen & Smidt-Nielsen, 1997, p. 17.) There are people needing help who have been tortured decades ago and people who have been tortured just recently. Clients may be young and old or men and women. The symptoms for the victim can last many years because the experiences they have been through are so horrific.

Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) includes the UN definition of torture. It says:

Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (Cited from Genefke, 1999, p. 5.)

Physical Torture. Physical torture methods can consist of beating, electric shocks applied to parts of the body such as the genitals, hours being forced to be suspended by arms or legs, forcing a head under the water until the victim is about to suffocate and burning a person with cigarettes or red-hot iron rods. There may also be systematic beating until for instance the soles of the feet have painful injuries, sexual offences like rapes, when women are treated as sexual objects and men are harmed, so that their functioning as a man is disabled. Filthy food and bad water is given to worsen the detention. Prisoners are also kept in small cells, their freedom to move is limited and they may have to sleep in turns. Victims are kept in poor sanitary conditions and using the bathroom may be restricted. (Vesti, Somnier & Kastrup, 1992; Jacobsen & Smidt-Nielsen, 1997; Genefke 1999.)

Psychological Torture. Psychological torture can include removing personal belongings at the time of arrest, such as glasses or important drugs etc. Victims may be changed into unfitting uniforms. The victim's name may be changed to a number and s/he may have to address the guards with deep respect. Other methods include restricting the sleep of a person, making them wear a blindfold and denying them any social contact. Mock executions are used and victims are made to torture

themselves. Victims are forced to see their loved ones and friends tortured without being able to do anything. With these kinds of methods, a torturer is trying to break the identity of a victim. Attacks against a person's identity may include forcing the person to say something bad about his or her political, religious or ethical view. (Vesti, Somnier & Kastrup, 1992; Jacobsen & Smidt-Nielsen, 1997; Genefke 1999.)

Symptoms and the Personality of Victim. As a result of torture the victim can feel that s/he is deeply guilty which is the objective of the torturer. Also the victim may feel a strong sense of shame. These are the mental consequences of torture after a person has perhaps been forced to give information about his or her friends. A victim can also be the only survivor of his/her friends and this may cause guilt. An individual may have been forced to make an impossible choice, such as choosing between informing the interrogator or seeing their loved ones tortured. Typical torture survivors' symptoms consist of emotional lability, sleep disturbances, disturbances in ability to concentrate or to remember, avoidance of thoughts and emotions associated with the torture, avoidance of activities and situations which arouse memories of the torture. Other symptoms may include an inability to form relationships with people, or a lack of interest in participating in meaningful activities, and a feeling that the future can only be seen in the short term. A person may act or feel like the torture is happening again and that their personality feels changed. They may also feel guilty for having survived, and they may suffer from anxiety, sexual problems and general tiredness. These consequences are all understandable reactions to such cruel and abnormal behaviour. The symptoms of torture survivors can be seen as a part of the post-traumatic stress disorder (PTSD) but there are some symptoms that are bound so strongly to an individual's culture that it may be difficult to fit the behaviour into a Western diagnosis (Mollica & Caspi-Javin, 1993, pp. 263–264). (Vesti, Somnier & Kastrup, 1992; Jacobsen & Smidt-Nielsen, 1997; Genefke 1999.)

Applied Guided Imagery and Music Technique in Treating Traumas and Torture Survivors

BACKGROUND

Music therapy has been used to treat and alleviate the effects of trauma for some time: The first university programmes of music therapy were founded after the positive results of treating veterans of the Second World War. It was reported that music and music therapy helped in cases of phobias, psychoses and in relieving

pain. In the 1950's music therapy and musical activities were being used in many veteran hospitals in USA. (Gaston, 1956; Ahonen-Eerikinen, 1998.) Later, after Vietnam, veterans were again helped with music therapy. This time however it was used more systematically and was theoretically developed with applied Guided Imagery and Music (GIM). GIM was developed by Helen Bonny and is based on a music therapy method and model which involved listening to music. Initially sessions could last about two hours and the client was encouraged to lie on a couch. Music from the classical repertoire was pre-chosen and tested for its ability to arise emotions or create images. The theoretical background stemmed from psychodynamic and humanistic theory. In the case of trauma clients, sessions last about 40 to 50 minutes, with the music part lasting about 20 minutes (Blake, 1994; Blake & Bishop, 1994). (Erdonmez Grocke, 1999, pp. 197-198.)

METHOD

In my clinical work with torture survivors I have applied a similar method. Sessions usually last between 45 and 60 minutes depending on the client how long s/he is able to concentrate on the therapy and the music. The music may be played for 20 to 30 minutes but it can vary. The client is encouraged to sit in a face to face position. The idea behind this applied GIM method is that a therapist offers the client some kind of theme from which to begin some imagery work. This could be "a sunny beach" for example. Music is chosen by me according to processes and the atmosphere in the therapy room. Or we may return to a theme or image that came up in a previous session or discuss, for example, how the client feels about the changing season. These kinds of themes may help the client to orient his/her thoughts to future and to further elaborate on them. Usually I begin with some slow, peaceful music to relax, calm down and orient the client together with verbal instructions. This does not take long and afterwards I give a theme to the client who can start to imagine. The difference between this application and the original Bonny method is that the therapist discusses and guides the imagery throughout the session for the client. For example I may ask some clarifying questions like "where are you now?" or "what do you see?". The client is also encouraged to begin to talk when images arise. I might then ask some further questions such as "what kind of forest or house can you see"? Sometimes when I notice that a client may be dissociating with his or her emotions I may confront them by gently asking "how does it feel to be there?" or "what do you feel?". The purpose of this is to help the client find his or her feelings again, which may have been isolated and numbed because of the severe trauma they have suffered.

If things seem to be going wrong and the client is going too deep into the process of emotions and imagery or is about to diffuse mentally, then I might guide the client elsewhere in imagery and emotions or lead him/her back from the theme and music

to a real situation. However, in my experiences with torture survivors this has not been the actual problem in therapy; rather it is usually the resistance of the client and the defences of the client which may make the imagery process almost impossible sometimes. In this situation we may just listen to music. It is important to remember with trauma clients and especially with torture survivors that a therapist is not forcing the client to anything, even to listen to music. The client has the right and permission to choose whether s/he wants to listen to music. If the client is not ready or does not feel like listening to music, I may encourage them to say so and make it clear that we can just talk. Usually when the music listening part ends I will guide the client back from the imagery to the real situation and where we are. After this we go through the experience and discuss the images, emotions, memories that have been brought up. Then I may ask some confronting and clarifying questions or try to interpret what the imagery may have symbolised and think of it in relation to a client's past or personality. Therefore the discussion may lead to traumatic memories and experiences but I never interpret during the music. Music listening and discussion during the music happens in a "here and now" situation.

Theoretical Background for Treating Traumas with Music Psychotherapy

The objective of this method for PTSD clients and torture survivors is that they learn to concentrate better with their intrusive thoughts and cope with their strong emotions. In this sense, music and the music therapist can be understood as an *auxiliary self* in a psychoanalytic context or a sort of a *ÒcoachÓ* or a teacher in a cognitive psychological sense. This means that the therapist sort of teaches the client to cope with his/her problems and work them through. The therapist's job is to try to pull the client back from intrusive thoughts and dissociative states, which s/he is not able to control by him/herself yet. Another goal is to enable the client to achieve positive imagery and feelings, which they may seldom experience otherwise. Therapy moves in "here and now" situations, especially while listening to music but also in the discussion afterwards. Here, the therapist attunes to the client and tries to understand their emotions, moves, stories, symptoms etc. By emphatic attitude it is possible that traumatised clients can learn and integrate new interaction models to themselves like Stern, Sander et al. (1998) propose and replace the distorted or failed models like in childhood development. Positive experiences and interactions begin to cumulate so that the client is better at coping with traumatised feelings and memories. This could be compared to the *procedural memory* where the pains and anxiety arise without words many times. Also the healing happens in the procedural memory in this sense.

MUSIC AS A HOLDING ENVIRONMENT

There is also the traditional view of trauma that encourages the re-experiencing of trauma with a therapist, so that the *corrective experiences* can occur. In my opinion, and this is also what Stern, Sander et al. (1998) suggest, these two different point of views on trauma are not contradictive. However, the healing happens in a *discursive memory* where it is possible to discuss the traumatic experiences. Here the traditional interpretations and insight therapy may be applied. However, in my own experiences, many torture survivors may not be able to discuss their trauma and some may even have blocked it from their memory. They therefore need more supportive treatment at first, for example by feeling that they are in a *holding environment*, which is shown to be of particular benefit for treating traumas (see Sutton, 2002).

The concept of the "holding environment" comes from Winnicott (1971/1997) who thought that the mother should hold the emotions, such as sadness, joy, anger etc. of a baby and create a safe atmosphere. He also meant general taking care of the baby's needs, providing food, warmth etc. This *holding* and taking care of the baby with a supportive attitude enables the developing of a self for the baby. Music may be applied in creating a holding environment for trauma victims. Music can be nurturing and bind various emotions that could be otherwise uncontrollable. Kohut and Levarie (1950/1987) proposed that the enjoyment of music has its origins in the early experiences and tensions between a mother and baby. The lullaby of a mother and her supportive presence may be later emotionally associated with music. Music therapists have applied this psychoanalytic knowledge in their work: Summer (1998) attuned to the client's emotions, imagery, music and interaction and chose music to mirror and hold her client's emotions in GIM sessions. Jensen (1999) described how he applied music to support, hold and create structure for a client suffering from schizophrenia. Austin (1996a&b; 2002) has used singing to hold emotions such as anger and the feeling of being used. In the initial phase of her Vocal Holding Technique she sings in unison with a client, so that the client can experience a symbiosis-like feeling and transference of merging safely as if with a stable mother. Later she adds harmony and mirroring to the technique, so that the client can feel the separateness in the relationship and also the new parts of personality can be heard and accepted when they are emerging. In Priestley's Analytic Music Therapy (1974; 1994) she describes a special technique called the *holding technique* where a therapist supports the clients' music and expression of emotions to the full potential by mirroring and providing a musical ground. One of the music therapy techniques defined by Bruscia (1987) is *holding* by which he means musically supporting the emotions. Nowadays it is quite common for music therapists to attune to their clients in a similar way to how a mother attunes to her baby, as Stern

(1985) proposed. Pavlicevic (1997) and Ahonen-Erikäinen (1998) have also applied this theory to music therapy.

In treating severe traumas like torture or PTSD it is important that therapy happens in a safe atmosphere and environment. Otherwise it may be impossible for the client to have a connection with his/her traumatic experiences, emotions and memories. These thoughts and emotions can feel so dangerous that the client does not want to encounter them at all, not even in therapy. Some of my clients have told me that these memories and emotions will ruin the whole day if they enter their mind in therapy. In this sense music may provide a safe environment for a discussion. Background music can even be played to help the memories and emotions arrive gently. However, the therapist has to attune to the client and music and must also be the supporter. Some of the torture survivors have not been able to discuss their memories, imagery and emotions even while listening to music. In this case we just listen to music, which can hold emotions and the structures of self because music may have a regular and peaceful rhythm or it may match the client's emotions and so provide enjoyable self control. When I just listen to music with clients who may have a weak sense of self boundaries and display psychotic symptoms I may ask some short questions about how they feel. I feel that this creates a safe and holding environment.

MUSIC AS A TOOL FOR EMPHATIC DESCRIBING

One important factor in providing therapy for torture survivors is to depict the clients' situations and emotions by talking about them or expressing them in music. Clients may have lost their own experiences of happiness, anger, despair etc. or do not have words for them. The therapist can describe how s/he sees the clients' situation and what kind of images and emotions it arises in them. Psychoanalyst Tshkz (1993/1997) has named this as *emphatic describing*. In his phase specific approach he has recommended this for borderline clients. Even though the torture survivors or other trauma clients are not the same as borderline clients they may still experience similar problems in their emotional life or have similar symptoms to clients with other emotional and social disorders. The describing of emotions provides the client with the possibility of identifying with a therapist, so that s/he may introject a more developed structure to his or her self. This means asking questions such as "how should I feel in this situation?", how is it to be in an interaction with another? what kind of person am I? etc. The client therefore may find lost experiences and emotions again in a relationship with a therapist and learn to cope with them. It is important to remember that torture frequently destroys the personality of a client and that s/he may have to begin to build it again with a therapist.

Music may be also thought of as a portrayer of diverse emotions. This can be done when choosing music for applied GIM sessions, in order to match the current emotions and atmosphere in therapy and in a client. Sometimes when a client has not been able to fully describe his/her emotions connected to the story or symptoms, I have asked what kind of music would fit them. Could it be sad, angry, powerful etc.? If the client has not been able to choose music by him/herself, then I may choose music to depict the client's emotions or client's situation. This requires me to attune to the client and employ empathic understanding, and choose music that has the ability to reach the client in a characteristic way so that it can work and I could choose music that touches the client and sort of comes from him/her. In Nordoff and Robbins' Creative Music Therapy, a classical music therapy technique called *reflection* is used which involves the therapist trying to make a musical picture of a child's emotions, movements, voices etc. (Bruscia, 1987, p. 46). This may be the early equivalent of emphatic describing in music therapy, although it comes from the another frame of reference. In this way, music can be one tool to provide understanding for the client and his/her sufferings. This can happen even on a non-verbal level and is important for torture victims because they are so often unable to speak about their traumatic experiences or find that words are not enough to describe the cruelty they have experienced and how they feel about it. To summarise: Music may provide trauma victims with a bridge to their past experiences and emotions, a link to their selves as well as to the other people. How should I communicate and describe my experiences? Who I am, how do I feel? In the beginning music and other art forms may help in this process of becoming oneself again. Music therapists can also verbally describe the music, emotions, problems of a client and how s/he sees them. This may also help the client to control his/her mind and to develop new coping strategies and structures in the sense of self.

Some Special Aspects for Music Therapy with Torture Survivors and Refugees

ACTIVE MUSIC THERAPY AND GROUPS

Other approaches have been applied to work with torture survivors too. This has happened in Germany and The Netherlands where the therapy has involved active music playing in a group (Orth & Verbugt, 1998; The BZFO reports 2000-2002). In this kind of setting it is possible to get a connection with one's own emotions and imagery. Rhythmic playing may provide a safe base for various emotions and make it easier to approach traumatic experiences and emotions relating to them. A client's personality may have been changed so that their personality and emotions have

split. Their personalities may even vary from one situation to another, so that they may experience different personalities. This may result in something that I experienced with one of my clients who was always very nice with me and other staff in the centre and could collaborate but was always in some kind of mess and trouble with his communal social worker. In group music therapy with trauma-induced dissociative disorders a technique has been applied called the *splitting* of Analytic Music Therapy which aims to approach the traumatic emotions in a client. In the splitting technique a therapist or a group can play and express a client's diverse emotions that may feel too difficult to express herself or there may be hidden parts in a client i.e. the repressed and isolated emotions that cause the split in the personality. When a client plays music that represents the traumatic, restricted emotions, the therapist and the group can share this experience by mirroring it in their playing. In this context too music may provide a portrait of a client and his/her emotions. It is also possible to share this experience with others and learn to communicate one's emotions. The holding environment and the safe grounding of music and emotions in the "here and now" situation are emphasised, so that clients can express their traumatic emotions and share them with others. When the traumatic experience has been encountered within the music, it is not necessary to isolate these emotions anymore and so the splits in the personality may disappear. This is the objective of therapy. (Volkman, 1993.)

I suggest that active music playing may have potential for trauma victims and torture survivors because it enables people to control emotions by themselves. For instance, when the client beats a drum s/he can control his/her own movements and dynamics and how often and how hard or slightly s/he plays the drum. Similarly, the traumatic experience and emotions relating to them may be controlled while playing a drum or other instrument. These kind of responses in music therapy have been reported in assertiveness training and anger management in work with adult and adolescent survivors of trauma. (Sloteroff, 1994.) This may be one reason why active music therapy has worked with torture survivors and other trauma clients as well. Other reasons are that music in itself activates and brings joy and belief in oneself and can help people to feel that they can manage (Orth & Verbugt, 1998; The BZFO reports 2000-2002).

LANGUAGE

In groups and active music therapy sessions interpreters may not be always necessary as they are in verbal therapy sessions where imagery is discussed. The communication may happen mainly within the music and between musical instruments that are played. In individual therapy I have used interpreters which makes the psychotherapy situation different because the transference does not direct only at the music and therapist but also at the interpreter. It is important that the interpreter is

always the same person, so that it is easier for the clients to trust him/her and therefore enable them to tell his/her experiences without shame. The experience in our centre is that it is possible to do psychotherapy with an interpreter. To make this easier I have instructed the interpreters for music therapy sessions and tell them about my methods and work. I ask them to relax in therapy sessions and enjoy the music. This is to make the whole music therapy session a more creative and safe experience. With imagery I instruct them to interpret and tell me everything word by word when this is possible and I ask them not to ask clarifying questions while listening to music or otherwise. I explain that this is my job in the sessions and asking too many questions may guide the client somewhere I do not want them to go, or at least without me knowing it. These kinds of meetings and discussions have been helpful for both, me and interpreters, and they have cleared our professional roles in a session. In these meetings interpreters have also a possibility to relieve their emotions relating to therapies where horrible things sometimes arise. However, usually our interpreters are quite experienced.

CULTURE

A client's culture is an important and useful consideration when providing music therapy for refugees and torture survivors. It is recommended that a therapist familiarises him/herself with a client's culture. There may be great differences between Western, Arabian or African culture and clients may have totally different religious beliefs, juridical and medical systems. For example, religion may play an important part especially in Arabian/Muslim cultures, magical beliefs still exist in African culture which may make it difficult to understand the client's background. One client of mine, who was a Christian, called me a "medicine man" after a strong transpersonal experience he had in an applied GIM session. Western classical or pop music can sound strange to some clients because they do not understand the structure of the music and words. In this case we may listen to some music from the client's own culture which is in his own language. This occurred in some of my work with a Bangladeshi client. Music therapy may therefore become a sort of cultural dialogue and exchange where the therapist learns from the client and vice versa with the help of music. Many of our clients are asylum seekers and in many ways need support to adapt to Finland. For example, climate differences can have a big impact and it may be a total shock to come from Congo to freezing Finland in winter. Music therapy may help in this process.

ASSESSMENT AND MUSIC IN TORTURE

When considering music therapy for a torture survivor it is important to screen in the assessment whether the client has been tortured or humiliated with music. Music was applied systematically in Nazi concentration camps to humiliate and

deceive prisoners. Music is also applied in prisons nowadays where patriotic military music may be played 24 hours a day to brainwash prisoners and keep them wake and prevent them from talking to each other. Serbs applied music in the Balkan war to humiliate and cause more suffering to Muslim prisoners. Music may have been played in the background while physical torture occurred. This could have been beautiful classical music that the torturer liked and therefore may have made the torturing easier for him/herself (Moreno, 1999, p. 5.)

It is important for the music therapist to know what kind of music has been played or been exposed to the client and when, so that s/he will not accidentally re-traumatise client by playing the wrong music. Clients may also react to different sounds such as loud traffic, tv, radio etc., which may arise anxiety and panic reactions and even cause physical reactions. This is why the music does not have to be loud to produce emotions and imagery in music therapy and it is wise, especially at the beginning, to be careful with powerful music from the classical repertoire. I have often noticed that beautiful and peaceful music that relaxes will eventually bring the traumatic experiences and memories to surface after some time where they can be discussed. Shock reactions are not needed with torture survivors and it would be ethically wrong for a music therapist to cause extra anxiety and pain to clients. The new structures and interaction models in a person's sense of self will only emerge together with good experiences like in childhood development. Some victims may not be able to listen to music at all anymore because of the torture trauma they have been through, even though they may have loved music before. However, not all victims experience music as a cause for anxiety. They may still love music and it may be the only thing in their life that they still enjoy. Music can take them away for a while from intrusive thoughts and help them to relax and sleep.

With clients who are afraid of sounds and music is associated with their torture and pain, it is the music therapist's job to try and bring back the pleasure of listening to music. This kind of therapy may sometimes be challenging and a therapist should be aware of his/her countertransference and be able to discuss it in supervision if necessary because the client may somehow project the image of the torturer onto the therapist. In general, therapists are open to all kinds of transferences with torture survivors and on some occasions a therapist may be the greatest medicine man on earth and on others s/he can be an evil torturer. The torture phenomenon itself seems to result in strong emotions, projections, splits and resistance in therapists, teams, colleagues and in society. This is why I strongly recommend therapists and other professionals who work with torture survivors to have their own therapy and continuing supervision.

Conclusions from Early Experiences and Research

From the experiences of people from different countries, it seems that music therapy is well suited to be one of the treatment approaches for torture survivors. There can be receptive music listening methods as well as active music playing methods. Music therapy can take place as an individual session or in a group. Music therapy is currently one of the recognised treatments for torture survivors (Kira, 2002, p. 66). Music therapy and other arts therapies are also recommended for the treatments of PTSD because of their non-verbal potential for expressing traumatic experiences. In our centre music therapy can be adjacent to verbal psychotherapy and physiotherapy or primary therapy. The frequency of sessions varies from one or two sessions a week to one or two meetings in a month depending on a client and his/her individual needs. Therapy can be short or long-term. The feedback from clients has been similar to those experiences of music therapy with other trauma clients that I referred to earlier. A music therapy group is planned together with other group activities taking place in the centre.

Early results from the small pilot study of my doctoral research suggest that music and music therapy are useful for torture survivors. My research is phenomenological and studies the clients' own experiences during one year of music therapy consisting of weekly or fortnightly sessions. Clients experienced music therapy as a useful and meaningful part of other treatment. Music therapy to some degree lessened the clients' depression and angst. It also helped in controlling their emotions and encouraged them to speak about them. One client began to apply music, which was similar to that he had heard in therapy, at home to relax and cope with his different emotions and disturbing intrusive thoughts. Clients experienced music therapy increasingly more useful as the therapy progressed. Similarly the symptoms lessened and the conditions improved. However, the research and follow-ups are still not finished though the therapies have ended. The research experiences are based on only three subjects in music therapy, so one must be careful with generalising the experiences and results. The main material of the research will consist of transcribed therapy sessions from every year of therapy.

More research and literature of music therapy of work with torture survivors and other trauma victims is needed. My own research and clinical work has showed me many difficulties relating to the treatment and research of torture survivors. Difficulties have something to do with the fact that music therapy in this area is still quite new. This makes music therapy an easy target for resistance from clients and other professions. However, resistance to treatment and research is a part of the problems torture survivors have because trust is very difficult for them. This is why scientific research is needed to prove to the clients and teams that music therapy

can make a difference. Also the problems concerning being a refugee and an asylum seeker in Finland can cause stress for the clients and make their rehabilitation even more difficult. From my research point of view the *situation* of clients is emphasised, how they have changed, how can they adapt to Finland, how they are treated in society etc. In this sense music and music therapy could be keys between different cultures, understanding each other and providing a little more sharing, humanity and caring in the world.

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References

CHAPTER 4

Non-structured initial assessment of psychiatric client in music therapy

Ala-Ruona, Esa

Abstract

This paper is based on the grounded theory study, in which experienced music therapy clinicians were interviewed and their conception of an initial assessment were examined in detail. The main result of the study is a qualitative synthesis of initial assessment procedures, including the description of the process how a therapist gains his/her understanding of a client during an assessment period. In practice, an overall structure and a setting of assessment sessions enable practical activities, which are client-centered and usually non-structured. Activities can be seen as a chain of interactional conditions, under which the necessary data is collected: acting, experiencing, encountering, sharing and finally, discreet discussion of what happened and what is perceived. This leads furthermore to reflective working of a therapist and forming more whole conception of the client's situation and the elements related. When summing up an initial assessment period and drawing up conclusions, therapist uses several sources of information. The process of gaining understanding is constructive, and in an ideal situation the whole multidisciplinary team can take advantage of the cumulative knowledge of initial assessment in music therapy.

Introduction

Assessment in music therapy is getting more and more topical (cf. e.g. Sabbatella, 2004). Working as a music therapist in close relationship with other health care disciplines emerges many questions concerning different practices and music therapist's role as part of multidisciplinary team. Referring teams and doctors are interested in suitability of music therapy and its possible benefits for a client. Of course, the goal setting for therapy is important, as well as the reasons to choose music therapy when compared to other approaches, like verbal psychotherapy and occupational therapy. Among these questions is also, could music therapy offer some new information about a client, especially when client's communication is very restricted and confined. As professionals, we should be able to produce also high quality services, and conducting assessments and evaluation is seen as a part of those procedures. Prioritisation relates to assessment issues as well, because the needs of different clients' should be assessed and the urgency of the needed treatment should be determined. But that's only part of the story, because money, or actually lack of it, is quite usually the ground for prioritising different services, too.

The use of certain assessment models and methods is relatively uncommon, and in practice, music therapists usually have developed needed methods by themselves. This means a lot of diversity in every area and part of assessment work. There are different theoretical grounds and approaches, cultural and practical differences, and diversity in the language of music therapy (Aldridge, 1996; Wigram, 1999). There are no equal or certain ways to conduct initial assessments at least in Finland and presumably in most European countries either. This is the issue, which should be discussed both nationally and internationally in our music therapy community and education. Some common guidelines could be set, and some basic principles of assessment procedures could be defined.

In practice, what happens when a music therapist meets a client for first time? Or even before the first encounter, when a therapist is contacted for a new client who is to be referred to music therapy? Some anamnestic information may be available, but is it useful from the music therapist's viewpoint? The nature of music therapy work is, if possible, even more delicate within psychiatry than in other fields of our clinical work. When conducting initial assessment, a therapist must take into consideration the fact, that an essential part of assessment is building the therapeutic alliance. So, it is quite obvious, that a client is going to continue his/her music therapy with this particular music therapist, and for that reason, their first encounters are very important when building the therapeutic relationship and for the future and also for the success of the music therapy process itself (Horvath, 2000).

The overall demanding nature of psychiatric work sets rather high requirements and qualifications for the music therapist's competence. At least in Finland, the clinical practice of music therapy is very independent by its nature, and on the other hand, the multidisciplinary collaboration is increasingly integral part of the work (Ala-Ruona & Jordan-Kilkki, 2004). Usually teamwork can be seen as a resource, but it can have its limitations, too, depending on the level of communicativeness of the team and its members. One of our challenges as professionals is, how we make our information communicate with other members of teams and beyond the likely barriers of different frameworks. Interesting and important question is also the overall validity and credibility of music therapy assessment. (Wigram, 1999; 2000.)

A brief review of the study

Although this paper is not focused on research process (Ala-Ruona, 2002; 2004) itself, some basic information on how this study was conducted may come in useful.

When I was working as a music therapy clinician within specialized health care, I got more and more interested in assessment issues and what actually happens right at the beginning of the therapy process. At early stage, I considered studying my own work as clinician, but I thought that reflective and hermeneutic study could not possibly emerge basic information from this topic wide enough.

RESEARCH QUESTION OF THE STUDY

So I ended up to examine different views of other music therapists and what information they consider essential in initial assessment and how do they get that information they want. Because of the lack of common terminology, I had to examine first what are the main concepts related to initial assessment and how therapists define them.

QUALITATIVE RESEARCH

When studying different concepts phenomenography is possible as a research approach. The basic idea of this approach is not to study the phenomena as such, but rather by mapping the qualitatively different ways in which people experience, conceptualise, perceive and understand it (Marton, 1988; 1994). In this study of mine, I used phenomenography as a starting point to examine these various aspects

of initial assessment through other clinicians experiences and how do they perceive them. The focus of the study developed during the research process and on later stage of it I applied also grounded theory as a complementing approach to get deeper in analysis and to be able to summarise the description of initial assessment process as a whole. I adapted mainly the coding paradigm developed by Strauss & Corbin (1990; 1998), because of its flexibility and suitability to former stages of phenomenographic data analysis. These two research approaches and methods supported each other in this study in fairly natural way.

INTERVIEWS AS MAIN DATA SOURCE

I conducted five focused in-depth interviews of trained and experienced music therapy clinicians. Their working experience as music therapist was from 10 to 20 years. The only question, which I presented to all of the interviewees, was the opening one: "Describe how do you act, when you get informed about a new client who is going to be referred to you?" By asking this particular question, I led the interviewees to discuss the situation right at the beginning of assessment procedure.

After this, the discussion was progressing as free-formed conversation. However, I had a list of possible areas of discussion as an interview guide (see Kvale, 1996), but usually I didn't need it too much. Conversations were rich and deeply reflective. In most cases, as the interviews progressed, the interviewees seemed to perceive also better how they actually work when doing assessments. This may prove that we were able to reach at least some of the tacit knowledge of these clinicians.

COMPUTER-AIDED DATA ANALYSIS

The interviews lasted typically from two to three hours and therefore I got huge amount of data to analyse. I utilized the QSR Nud*ist (Richards 1998) program for organising and analysing the collected data and found it really useful particularly for its powerful search options. First I studied different concepts, which the interviewees used and defined. After that I got deeper with the analysis and organized the data into categories and upper categories. The last stage of data analysis was to create the qualitative synthesis of categories and especially to find the core category which "tells the story" of collected data (a storyline, which answers to the research questions; see Strauss & Corbin, 1990; 1998).

In this study, the storyline appeared to be the progress of gaining understanding in the initial assessment process. This was the main (and core) category to which all the other concepts and categories were related somehow systematically. The final

stage of analysis was very demanding and time-consuming to do. I analyzed the data once more in higher conceptual level and formulated (or modeled) a big scheme, which describes to process of initial assessment in music therapy when the assessment is conducted in non-structured way (without scripted content or certain tasks).

MEMBER CHECK

After analysis of data and forming the main findings of the study, I sent them to the participants to find out how well the results matched with the experiences of their own. The results of the study were accepted and the feedback was actually very positive. The participants emphasized the successful description of the initial assessment procedure, which is very complex and multi-level phenomena consisting practical, theoretical, framework- and clinical experience-related issues.

The main results of the study

CHARACTERISTIC TRAITS OF INITIAL ASSESSMENT

According to this study the characteristic traits of initial assessment are:

- It is carried out as a process. The initial assessment is usually based on a period of several appointments (up to 6 sessions).
- A client-oriented approach means that the initial assessment is always tailor-made. There are no certain tests or other formal ways to conduct the assessment.
- Investigation of interaction is the most essential form of gathering information during assessment period. Interaction between client and therapist is observed in musical, verbal and non-verbal relations.
- Another important area to be studied is client's relationship to music. This area is usually assessed by listening to music, which is important or of present interest to client. This brings the contextual aspect to assessment.
- When summing up an initial assessment period and drawing up conclusions, therapist uses several sources of information. This procedure reminds triangulation, which is a concept taken from qualitative research terminology. Several data sources are used in order to ascertain the accuracy of collected information.

DESCRIPTION OF INITIAL ASSESSMENT PROCESS

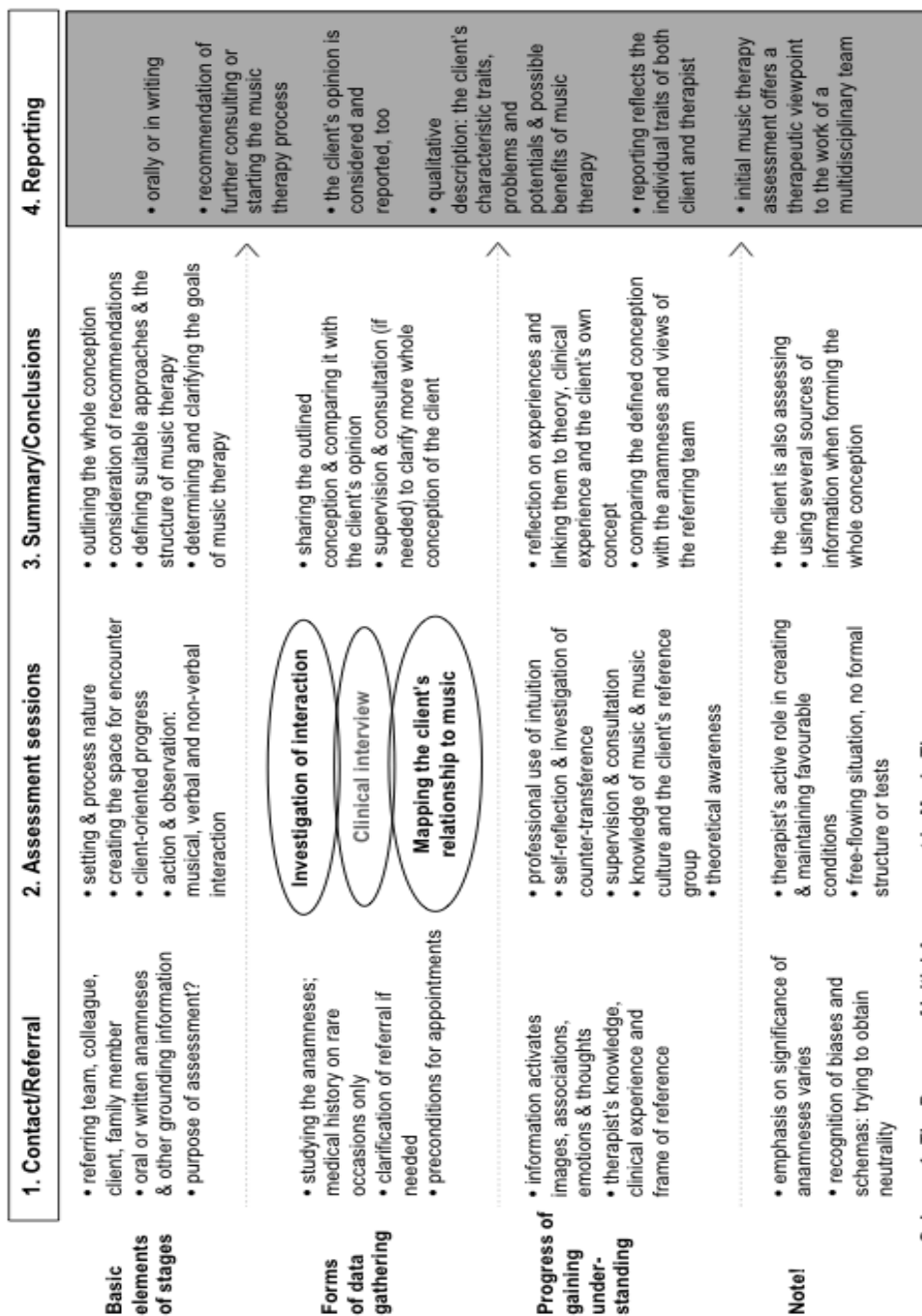
Next we shall have a closer look to the process of initial assessment as a whole.

FIGURE 1. Process of initial assessment in music therapy

The Process of Initial Assessment in Music Therapy

Non-structured Assessment of
Psychiatric Client in Music Therapy
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Chronological progress of assessment



Scheme 1: The Process of Initial Assessment in Music Therapy

Figure 1 is qualitative synthesis of assessment procedure, and this big overview shows the main results of the study. We can examine the process of initial assessment from three points of view: its chronological stages as numbered, the forms of information gathering on line two and the development of therapist's understanding of a client from line three. In other words, this description can be viewed as both horizontally as lines and vertically as columns.

Now we will take a closer look to certain elements of the big scheme. First we examine the very beginning of the assessment process. Then we will study what happens in assessment sessions. The main interest is especially focused on how therapist's understanding of a client develops during the assessment period.

THE PROCESS OF GAINING UNDERSTANDING

At initial phase. The first column in figure 1 describes a starting point of assessment procedure containing first contact and referral. Oral and written anamneses are got through and the purpose of assessment is also defined. In practice an assessment may be focused on the client's need for treatment, suitability of music therapy as method of treatment, goal-setting of music therapy, finding appropriate music therapeutic approaches, collecting new information for planning of whole treatment etc. (cf. Bruscia 1987, 13; Sabbatella 1998, 227; Wigram 1999, 8; Wilson 1990, 131-136.)

However, the significance of this grounding information varies a lot. Some of the interviewees actually emphasized, that they are not very interested in anamneses and other previous knowledge, because they want to make a fresher start when assessing, and collect the needed information from their own point of view (also framework-related issue).

This first stage of initial assessment is, of course, also the phase where the process of forming understanding begins. As soon as a therapist gets some information of a new client, it activates different images and associations, as well as emotions and thoughts related to them. From the point of psycho dynamic view, this is the point where counter-transference starts to develop for first time. Therapist's previous knowledge, clinical experiences and frame of reference are used when outlining this material.

A therapist tries to recognise his developing preconception and tries also to obtain neutrality when meeting a client for first time. Different self-clearing (see Bruscia, 1998) procedures are applied and careful self-reflection is used when preparing for meeting a new client.

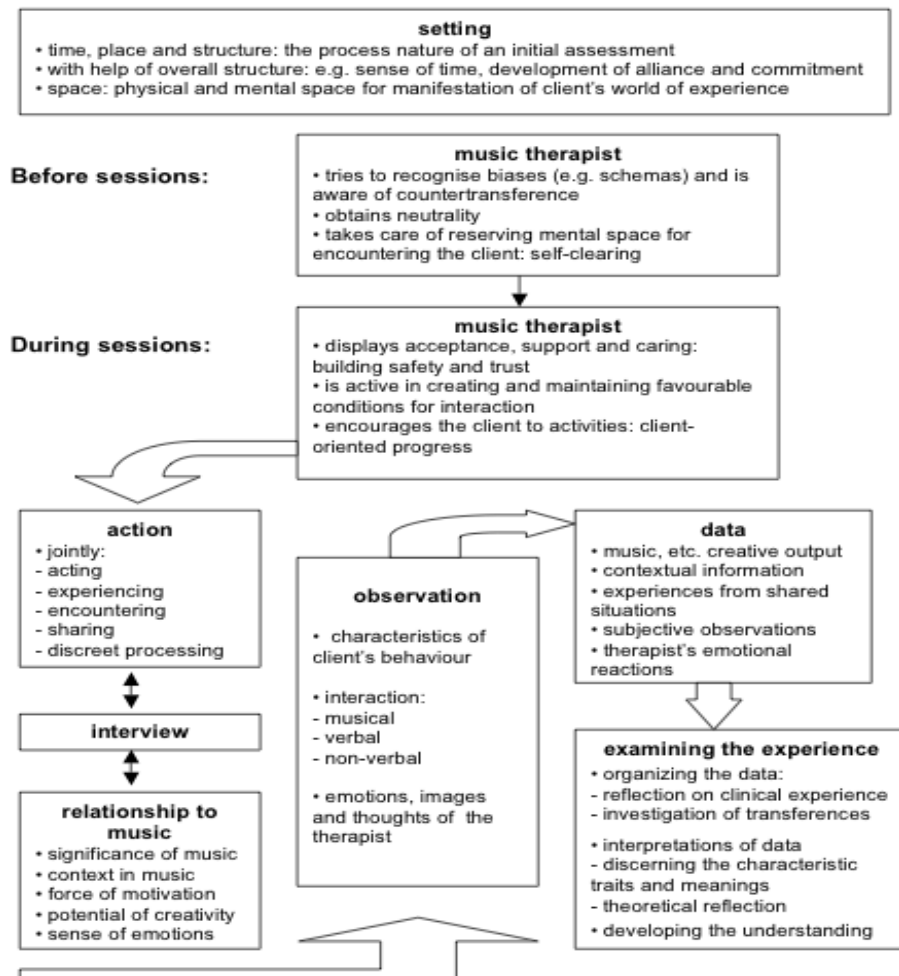
Assessment sessions. Next we shall investigate the assessment sessions.

It is important, that the overall structure of assessment procedure kind of imitates the therapist's characteristic way of working. It means for instance, that if therapist's orientation is supportive, appointments could be arranged as once a week. But if working more intensively, the assessment is conducted in the same way. This relates also to a therapist's frame of reference. In this study, most of the therapists named psychodynamic theories as their framework, however there were hints of applications of cognitively oriented learning theories, too.

Next we shall go further and discuss some more of the issues concerning the setting and other concepts related to assessment sessions.

FIGURE 2. Assessment sessions

The purpose of an assessment, the individual needs of a client, therapist's characteristic way of working and the overall nature of assessment work influence to the formation of initial assessment process.



Scheme 2: Assessment sessions

The setting (or therapeutic setting) is integral part of initial assessment. Certain place, time, room, person and the overall structure of appointments are the foremost requirements for successfully conducted assessment.

The process nature of assessment is important due to possibility to observe the client in several situations and repeatedly. The structure itself enables to assess important areas concerning for instance client's engagement and orientation to time and place, and to determine the appropriate structure of planned music therapy.

A therapist tries to obtain needed neutrality, concentration, readiness and willingness to encounter a new client. He has to be also aware enough of different biases and preconceptions concerning a client and on the other hand his own mental and general situation.

During the sessions (in figure 2). When meeting a client, therapist's main task is to create and maintain favourable conditions for interaction. Purpose is to enable client's personal way to act, express oneself and his/her representation of inner world to come up in situation.

Different hopes, fears and needs of a client emerge in musical or non-musical way as the relationship starts to develop. Therapist's task is to try creating atmosphere that is safe enough and enabling the development of confidence. This is usually done in both verbal and musical way. Therapist is an active agent when creating favourable conditions for interaction and especially when working with children or adolescents. Musical activities work as flexible and variable ground for different forms of client's creativity and qualities to come up.

One of the main concepts is client-oriented approach, and it means that there is no certain formal way to conduct the assessment sessions. Even though the assessment period itself is well structured, procedures and activities vary depending on client's needs, resources, problems and individual orientation. Important is to do different things together and get shared experiences through several activities.

Thinking about the role of therapist, balancing between active involvement and free-flowing progress requires sensitive self-awareness and sense of situation.

Action (in figure 2). In practice, in the beginning, the therapist usually introduces therapy room and its facilities. A client is allowed and actually encouraged to try the instruments. As soon as something happens, therapist usually joins in activity. Spontaneous clinical improvisation is very typical method and approach. Situation

is usually free flowing and is based on musical and behavioural flexibility of a therapist. (cf. Loewy, 2000.)

Although neutrality is obtained when meeting a client, in playing situations there should be more room to creative and spontaneous reactions. What if playing is neutral? Is it even possible to play something and share anything without emotional involvement? However, a therapist should be able to receive all possible musical or non-musical material from a client and work as container. This requires continuous alertness and readiness from a therapist.

Creating improvised music together opens wider viewpoint to a client's spectrum of emotions and inner world than what is usually reached in verbal interaction. While defensive behaviour is more obvious in verbal interaction, using spontaneous music making is seen much quicker way to perceive something essential of client's world.

If possible, the shared experiences are however discussed together. Exchanging the views on shared situations offers an opportunity to assess client's cognitive and other mental qualities. How do a client perceive him/herself and what kind of abilities of gaining insight he/she have. Verbalising experiences and musical content is not seen as necessity, but if seen appropriate, it is applied. The special focus is in a client's latent potential, which emerges possibly in musical situations and relations only.

Clinical interview of client (in figure 1 & 2). Therapist may interview the client if needed to get more information of overall situation and especially from client's own point of view. Usually this is done informally and no certain questionnaires are used. Interviewing a client is more like spontaneous conversation in different situations and it is more or less related to musical activities.

MAPPING THE CLIENT'S RELATIONSHIP TO MUSIC (IN FIGURES 1 & 2):

Another integral part of initial assessment procedure and form of information gathering is mapping the client's relationship to music. While investigation of interaction concerns what's going on between client and therapist, mapping the client's relationship to music serves more like studying what is fundamental to client's intrapersonal qualities as reflected to music.

Therapist introduces the available music, but makes no choices. Client chooses the music (and may bring his/her own music with too). After listening to music, different thoughts, images, associations and emotions emerged, are to be discussed if

possible. This gives the opportunity to study what is characteristic of client's music. It elicits clues of cultural relations and important experiences in different phases of life as well as hints of symbolic and emotional connections related to music. For example, client's relationship to music may reveal age-specific issues and how well he/she is connected to presumable music culture according to his/her age. This is especially assessed when working with adolescents. Other important clues could be for instance: important persons related to client's history, social relations, emotional tensions and overall present situation of life.

Although the main interest when mapping the client's relationship to music is intrapersonal by its nature, it offers however contextual aspect and gives additional information when trying to understand the nature of interaction between client and therapist, too. This contextual horizon may or may not confirm the previous understanding and it may open deeper and wider perspective to perceive the world of a client and to recognise the fundamental elements of relationship between a client and a therapist.

Observation (in figure 2). The observation in assessment situations is conducted at several levels with different focus. One level is therapist's own emerging emotional content. The other is interaction between a client and a therapist: what is the general nature of it. The third one is the overall observation of client's musical and non-musical behaviour in sessions, and comparing it to his/her behaviour in other situations. Observation during the sessions is based on subjective perception and observations are not usually systematically rated nor analysed.

Data (in figure 2). When thinking the initial assessment as a research, we may consider all the material from the sessions as "data". This box contains examples what kind of data we can get from the assessment sessions.

Examining the experience (in figure 2). When examining the experiences of assessment sessions, therapist's intuition acts directing the attention, and earlier clinical experience acts like a guide. This means that when working with intuition, therapist have to be careful not to believing everything that intuition points out. Therefore, the conclusions are not done based on intuition only without reflecting those emerged ideas carefully first.

Self-reflection and investigation of counter-transference is used as main methods when analysing shared experiences. Counter-transference is understood here in the broadest sense of the term, in other words therapist investigates all the emotions and feelings, which emerge in interaction between client and him/herself. Self-reflection is very alike by its nature, but it does not have necessarily connection to

the same frame of reference. Or it can be understood more like the use of previous professional experiences.

Therapist's intention is to reach good enough level of neutrality and thorough investigation of emerging emotional content is used as main method to understand client's emotional qualities and mental state. Intention is to distinguish what is the origin of emotional content emerged in interaction. To be able to do this, a therapist has to be aware enough of his own background and how he has become as him/herself. One has to have active and constant intention to understand his present situation as well. Under these conditions, it is more possible to recognize what emotional content comes up from therapist's own world and what is reflection of client's inner tensions and thus presumably subconscious material by its nature.

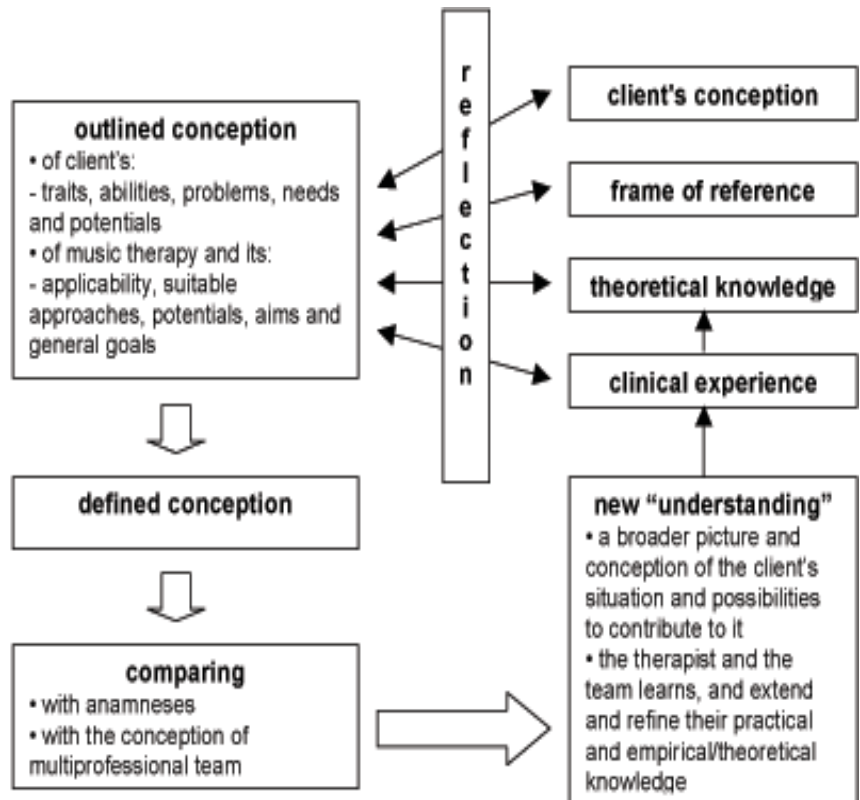
As a summary of assessment sessions, the whole procedure could be presented like this: Structure and setting enables practical activities, which are more or less free-flowing. Those activities can be seen as chain of different conditions, under which the data is collected: there is acting, experiencing, encountering, sharing and discussion of what happened and what is perceived. And further, this leads to reflective working of therapist, who tries to form more whole conception of situation and its elements. This kind of working method requires from a therapist very flexible switching between the creative and emotional involvement and on the other hand cognitive and theoretical reflection. This leads to form more whole understanding of client and his/her situation and the possibilities of music therapy.

FINAL STAGE OF AN INITIAL ASSESSMENT (IN FIGURE 3)

At the final stage of assessment the outlined understanding is reflected to the client's own conception. Remarkable is, that client is also assessing if working with this particular therapist and medium and with these instruments could be suitable for him/herself. The outlined conception also is reflected to therapist's frame of reference, to other theoretical knowledge and previous clinical experience.

This leads furthermore to defining the conception and comparing it to the anamneses and the conception of the referring team. In an ideal situation this contributes the learning process of the therapist and multidisciplinary team, and they may refine their practical and theoretical knowledge.

FIGURE 3. The final stage of initial assessment



Scheme 3: The final stage of initial assessment

Non-structured Assessment of Psychiatric Client in Music Therapy

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Reporting (in figure 1, last column). A part of the final stage of initial assessment process is reporting. It is done either orally or in writing. A possible recommendation of further counselling or to start music therapy process is presented. A client's own opinion is considered and reported, too.

Here is a summary of typical recommendations:

- the suitability of music therapy as treatment and possible need for further consulting
- the form of therapy: group or individual music therapy
- music therapeutic approaches suitable to client
- the goal-setting and possible outcomes of client's music therapy
- how music therapy integrates to other forms of treatment and how could they complement each other?

According to this study, it is actually easier to define when music therapy is not suitable for someone and therefore not recommended. Such conditions could be, if client totally lacks his/her sense of illness, or has an antisocial personality disorder, an acute stage of psychosis or a total lack of motivation and therefore is incapable to engage to planned therapy. These were the few conditions mentioned when music therapy could not possibly be recommended. Music therapy is seen so flexible as an approach that a client can usually benefit its possibilities at least to some extent. (cf. Lindvang & Frederiksen, 1999)

The report itself is a qualitative description of client's characteristic traits, his/her problems and potentials, and possible benefits of music therapy etc., and it reflects individual traits of a client and a therapist both. This kind of descriptive report offers therapeutic aspect and alternative viewpoint to the work of multidisciplinary team. Perhaps the most important quality of initial music therapy assessment is the opportunity to gather some information also under such conditions where other approaches don't work. Usually this additional knowledge collected can elicit something new, bring it available and benefit the work of whole multidisciplinary team.

Conclusion

This study describes the viewpoints of experienced music therapists and outlines a qualitative synthesis of initial assessment procedure of psychiatric client in music therapy. The phenomena appear as multifaceted and multi-levelled as music therapy work usually is. The non-structured initial assessment is particularly interesting for its flexibility as an approach. It seems to work well in very demanding situations with challenging clients. However, flexibility could present a problem, too, if considered from the point of music therapy education, since this kind of working requires quite a lot well-integrated skills from a therapist. Music therapy students or

novice therapists don't have that previous clinical experience and tacit knowledge, in which experienced clinicians partly rely on. The question is, how to teach such assessment skills? Is it obvious that we end up using rigid questionnaires, checklists, rating scales etc., and lose the important flexibility at the same time? Compared with research approaches, non-structured initial assessment is very qualitative by its nature, and the "data" from sessions is somewhat thick and complex. One practical problem is, that we get huge amount of data and have usually only very little time for investigate it. What we could need is a quick enough and easy to use method for structuring and analysing the data from free-flowing assessment sessions. This tool could bring some quantitative data into assessment, serving probably as a tool for evaluation of change in therapy process at the same time. Perhaps the computer-based analysis for clinical improvisations (Erkkilä et al., 2004) can bring some new possibilities to assessments, too. Sensitive and vulnerable interaction between client and therapist is nevertheless the basis, which should be respected, and not to be interfered by applying inflexible tests or other possibly restricting elements to creative sessions.

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CHAPTER 5

*Woman to woman in improvisational
music therapy: the formation of a
relationship*

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Introduction

From 1999 to 2003 I worked with a woman who has severe cerebral palsy and is non verbal. We had a total of 103 1 hour individual sessions. Barbara, age 52, can

indicate “yes/no” by moving her head in response to “yes/no” questions. She does not have intellectual difficulties and can use a communication book, when needed. Despite challenges and losses, Barbara is remarkably willing to engage in life. In sessions, she participated through the quality of her listening, levels of emotional intensity, and non verbal responses (e.g., body movements, the stillness of her body, gestures, changing facial expressions). She also interacted musically through vocal sounds, and playing accessible instruments.

With all possible gender combinations, gender plays a key role in therapy (e.g., Bruscia, 1995; Meadows, 2002; Rogers, 2003) But, as Ernst states, “...there is something particularly powerful in the interaction between the two women in the therapy relationship which can best be grasped in gender terms” (p. 26). The title of this paper begins with the phrase “woman to woman.” This phrase implies that relationships between women have particular qualities. Today, I’d like to present some reflections on my work with Barbara and qualities of our relationship that developed over 4 years.

Writing from the Stone Center at Wellesley College in Massachusetts on the psychology of women has been an important source of understanding for my work. Authors at the Stone Center propose alternatives to a therapeutic discourse that emphasizes “ independence and self-sufficiency...[as] the hallmarks of maturity” (Miller & Stiver, 1997, p. 2). Instead, they emphasize that “ *the goal is not for the individual to grow out of relationships, but to grow into them*” [italics added] (Miller & Stiver, 1997, p. 22).

Key ideas in this relational model of women’s development helped me understand how the relationship with Barbara was formed and developed. These ideas are:

- connections and disconnections
- the power to empower
- mutual empathy and mutual empowerment
- movement in relationship

Gilbert & Scher (1999) summarize “ key aspects [nine] of feminist and gender-aware approaches to therapy. Four of these aspects were also germane to the relationship with Barbara: (1) Demystification of therapist power in the therapeutic relationship, (2) Ongoing self-examination of values on the part of the therapist, (3) Valuing the female perspective, and (4) [a] Focus on women’s empowerment” (p. 70).

Connections & Disconnections

Connection is defined as “an interaction between two or more people that is mutually empathic and mutually empowering” (Miller & Stiver, 1997, p. 26). Disconnection is defined as “an encounter that works against mutual empathy and mutual empowerment” (p. 26). A relationship is usually a mix of both. A vital aspect of growing into relationship is the mutual link between “being in connection” and “being emotionally accessible.” (Miller & Stiver, 1997, p. 45).

How did I relate to Barbara? As a disabled person, with no consideration of her gender? As a woman, with no consideration of her disability? As a disabled woman? Yes. I saw her as a disabled woman. Basic rights that I take for granted as an adult able bodied woman are not available to her. The pleasure of eating was taken from her several years ago when an inappropriate feeding necessitated surgery and a permanent G Tube. Such simple, conventional possessions of femaleness such as a purse or adult resources such as a credit card are denied her. Barbara’s full first name and last name were seldom used. Perhaps this was her preference? The use of clients’ last names are often “hidden” for confidentiality reasons. But perhaps a shortened version of her first name was a small example of the “denial of adulthood.” Sinason (1997) remarks that “...linguistically denying adulthood perpetuates [losses due to mental or physical challenges]. There is [also] an additional gender pressure...to remain a ‘good’ non-sexual girl” (p. 174).

Barbara cannot walk, talk or look after herself, that is, she cannot wash, dress, eat or eliminate on her own. She *has* to rely on others. Being seen as a woman predicates that a physically disabled woman is (or was) potentially capable of sexual activity and child bearing. However, Barbara’s biological capacities as a woman didn’t really enter into my reflections about the music and the therapeutic relationship. The visual aspect of her physical challenges was apparent. But because she’s a 52-year-old physically disabled woman, I may have inadvertently made her “invisible” by not considering the full extent of her biological losses.

The Power to Empower

The issue of power is always important in therapy. A growth-fostering relationship, however, is “...creating something new through interacting with another person” (Miller & Stiver, 1997, p. 38). Facilitating growth in relationship requires power, but not in the usual sense of the word. Rather than domination, one’s power can be

used to facilitate growth. This "...is not power over others...it is 'power with', a power that grows as it is used to empower others" (Miller & Stiver, 1997, p. 16).

In her Field of Play theory (1989) Carolyn Kenny also gives power a different meaning that is linked to ancient healing practices. Power is essential for the creative process towards health. It "is that cumulative energy which draws one into new possibilities..." (p. 88).

As Barbara's therapist I was responsible for providing a safe physical as well as emotional and relational environment. There were obvious differences in physical capabilities between us. I also determined the structure of sessions, e.g., time, place and length. Perhaps in my role as protector I saw Barbara as a female "child"? But this didn't feel right either. Contributing to growth-fostering relationships is not simply about "nurturing." Ernst (1997) cites Orbach and Eichenbaum (1993) as saying "...more is needed than the therapist's holding of the client...the client needs most of all something which, because of the nature of gendered relationships, she is unlikely to have had in her relationship with her mother: namely an encounter with another 'subject'" (p. 29). However, it's a conceptual stretch to assume that all women have not had aspects of an intersubjective relationship with their mother, let alone other women in their family or community.

There were aspects of my relationship with Barbara that felt, and could be interpreted as, "mothering" such as a depth of connection and musical comforting. The context of individual sessions is intimate and private. In music therapy approaches such as Analytical Music Therapy and the Bonny Method of Guided Imagery and Music, authors describe "mothering" aspects of music and the musical relationship, plus mothering qualities of the therapist's role (e.g., Kowski, 2002; Priestley, 1994; Ventre, 1994; Summer, 1995; Warja, 1999). Sometimes Barbara was in physical pain and my role in the musical relationship was to comfort as best I could.

VIGNETTE 1:

In session 16 (March 22, 2000) an improvisation developed into lullaby like music, entitled *Lullaby in G minor*. As this improvisation progressed, the spirit of the session changed, evolving 'back in time.' A deeper level of musical relationship was reached that possibly connected to Barbara's younger past. I introduced a bass ostinato at the piano- G, B flat, A, D. Improvised lyrics (summarized) were 'Pain never goes away...makes me feel so tired.' Descending minor seconds gave the music a quality of sighing. The spirit of the music was child like with simple two part counterpoint and qualities of sleepiness and rocking in a 6/8 meter. The music, which

ended in E flat major, seemed to hold Barbara's vulnerability as well as meet the sounds of her yawning and breathing" (Arnason, in press, p. 10).

But I was cautious of making psychoanalytical interpretations of my work with Barbara. This theoretical language was not particularly helpful in understanding how we related musically and interpersonally. Since Barbara cannot speak, my direct knowledge of her past life was minimal. Most background information had been communicated by professionals or her older brother. Gilbert & Scher (1999) state that psychotherapy embraces "...therapy processes [that] rely on clients engaging in self-awareness and reflection, expressing feelings and vulnerabilities, discussing problem areas, and trusting in the helping relationship..." (p. 53). Barbara engaged in the process, expressed herself, and trusted in the relationship. But I could not interpret Barbara's level of reflection or self-awareness. She cannot verbally describe her inner life and it's unreasonable to ask her open ended questions. It was also problematic to interpret the meaning of Barbara's body language because her physical movements were not always intentional.

Mutual Empathy and Mutual Empowerment

Mutual empathy is the source of mutual empowerment. Authors at the Stone Center emphasize that "[mutual empathy] is...a joining together based on the authentic thoughts and feelings of all the participants in a relationship...simultaneously, each person enlarges [and is enlarged by] the relationship" (Miller & Stiver, 1997, p. 29). In the search for mutuality, the relationship with Barbara grew to be egalitarian, i.e., mutual and participatory. Although I played most of the music in sessions, she had the power to empower my capacity to be observant and reflective as well as to access different levels of listening. Surrey (1997) describes "mutuality" as "...a creative process, in which openness to change allows something new to happen, building on the different contributions of each person" (p. 42). As Miller & Stiver (1997) explain, "...power differentials don't have to preclude genuine mutuality" (pp. 43-44). .

Movement in Relationship

Miller & Stiver (1997) describe the experience of being genuinely moved in therapy:

This experience of being moved by a patient's feelings, authentically and powerfully, requires the therapist to be open to experiencing her own emotions; in this process therapists can allow themselves to be moved and to convey this at some level to their patients...we believe it is the very openness to her own feelings that allows the therapist to truly resonate with patients...*we do not believe that feelings keep therapists from good thinking and good judgment. Indeed, it is the reverse* (p. 125).

During the course of therapy with Barbara, there were moments when I felt a shift or movement in our relationship. Being together steadily grew into a relationship with qualities of subtleness, candidness, compassion, playfulness, and mutual involvement. There were times of gentle teasing, pain, disagreement, and laughter. Relationships are described as "moving, dynamic processes...what matters in people's lives is whether they can feel that they are moving, that they can make something happen..." (Miller & Stiver, 1997, p. 53). Authenticity kindles movement in relationship. For both the client and therapist, authenticity "is a person's ability to...[be] in a relationship with increasing truth and fullness...[and] to respond...If we do not respond there is no flow, no movement" (pp. 54-55).

VIGNETTE 2:

In the second half of session 73 (April 16, 2002) Barbara and I were concentrating on music that related to her father. Barbara's father had been diagnosed with prostate cancer and his health was not good. A musical theme (developing song) about her father was explored. We sang the song *Bridge Over Troubled Waters* - a song that had personal meaning for Barbara because it represented the loving support of her father over many years. Two minutes of silence followed this song and ushered in a "new" improvised song in A flat major entitled *Dry Your Tears*. The lyrics summarized were: 'When tears are in your eyes, I will comfort you. That's what Dads do. Dry those tears, make them go away. Dry those tears, that's what Dads do. They dry our tears until it's ok.'

Videotape Excerpt 1

In this improvisation, there was an interpersonal authenticity that went beyond the client-therapist relationship. I could only be open to Barbara and the musical experience by allowing the conscious awareness of personal feelings and memories to guide my playing. This affinity with another person underscores the importance of allowing human vulnerabilities and experiences to enhance our therapeutic work (e.g., Freeman, 2003, p. 60).

Transparency

There was a growing sense of transparency in the relationship with Barbara. Through the process of analyzing sessions, I noticed that my mental preparation began to change. I was more able to be in sessions with a transparent state of mind. This was a bit of paradox though since listening back to improvisations also filled my mind with thoughts and questions. This developing mental transparency seemed to allow the music to "show itself." In connection with my research study on listening, which was published in the *Nordic Journal of Music Therapy* (see reference list), I believe that this transparency grew out of a developing awareness of different levels of listening. One of the levels is actually listening *from* transparency, which is "...re-living an improvisation as it unfolds [when improvisations take shape in sessions and when listening back to tapes]...living in the now of the musical experience again. It is the practice of trying to free oneself from musical and clinical preconceptions and developing a fresh perspective on the original musical process" (Arnason, 2003, p. 130).

In regards to interpersonal transparency, I remember affirming how difficult it must be to have things you want to say and not be able to say them when you want to. The change in Barbara's facial expression showed the personal meaning this comment had for her. It felt very important, especially with a non verbal person, to name what needed to be said. In this way, Barbara could "be heard." There were also times that I "thought out loud", voicing my thoughts or feelings about an improvisation. Sometimes I shared my uncertainty about what kind of music Barbara wanted or needed, or whether she even wanted music. I didn't wish to speak for Barbara nor did I expect her to agree with me. My aim was to make my thinking process known. She then could agree or not agree. I made a point of acknowledging when it looked as if she didn't agree and admitting when I wasn't sure what her nonverbal response meant.

Gilbert and Scher (1999) stress the importance of nonverbal behaviors because they "appear particularly important in the establishment of rapport and trust between client and therapist and in the client's feeling heard and understood" (p. 144). Barbara's body and facial responses were sometimes difficult to see, let alone understand. A particular response could come "unexpectedly" or be ambiguous. Her facial expressions could vary greatly during an improvisation. Her musical responses could be quite intermittent, leading me to wonder about her level of engagement in the musical interaction. It seemed that "disconnection" in these instances was an inevitable part of forming a relationship. Emotional "checking in", therefore, was essential to "valuing Barbara's perspective" as a nonverbal and physically disabled woman. Gilbert & Scher (1999) emphasize that "the emotional

expression of feelings is...[a] strong nonverbal form of communication. Tears and laughter are of tremendous import, as are the facial expressions and body language of both the client and the counselor. *Because emotional expressions are often accorded stereotypical gendered meaning, their actual meaning for a client or therapist may be lost or misconstrued. Therapists need to be careful about making stereotypic interpretations...* [italics added] (p. 145).

Gilbert & Scher (1999) go on to explain that “areas of non verbal behavior particularly important in...gender dynamics are personal space and touch, time, facial positivity, and emotional expression” (p. 144). In social contexts, I noticed that people tended to touch Barbara without much awareness of what the touch might communicate (social gesture). In sessions, I worked to keep aware of the context in which I touched Barbara as well as her response to my touch. At times, there was the practical need to take off and put on her winter coat. At other times, I might touch Barbara in response to a particular moment or feeling she was experiencing.

As well as the interpersonal transparency that I’ve been describing, musical transparency was crucial. Because music is so powerful, I wondered if sometimes I was getting “too close” or being “musically overwhelming.” Was I invading Barbara’s “personal space”? Claire Flower (1999) describes her work with a nine year old boy who has severe cerebral palsy. She states that “a key issue in the growth of the relationship has been to do with waiting and listening closely” (p. 124). Flower admits that sometimes she was able to wait and at other times she “...[swamped] Steven with a kind of musical ‘mush’...perhaps, in my being busy and musically active, we none of us have to feel the reality of Steven’s disability” (p.126).

Transparency in music meant not only keeping aware of musical elements and their combinations but also staying attuned to qualities of Barbara’s presence. For instance, I worked to not overpower Barbara dynamically (volume/texture) when accompanying her on piano in songs. Transparency sometimes was musical distillation, e.g., the closing improvisation in session 79 (June 4 2002) ended in two part counterpoint. I aimed for musical clarity, i.e., listening for texture by paying attention to tones, intervals, and their combinations. I might play a bass line on piano without singing or playing a melody in order to support Barbara’s vocal sounds as melodic tones. By encouraging her voice in the music, Barbara’s identity could “be heard” and possibly strengthened. Because she’s nonverbal, silence was a familiar part of sessions. Canadian composer R. Murray Schafer affirms that “every piece of music exists in a container of silence (Lecture by R. Murray Schafer, Wilfrid Laurier University, January 15, 2002). The music co-created with Barbara often felt as if it was contained in silence. Improvisations that emerged from silence also had elements of transparency.

VIGNETTE 3:

The lyrics of *Wind Beneath My Wings* (session 87, November 7, 2002) represent Barbara's close relationship with her older brother. When I asked Barbara which song(s) she wished to listen to and/or participate in, she often chose this song. It was a very happy experience when her brother came to one of our sessions and heard us perform this song for him. In this excerpt, I'm not sure whether Barbara's hand movements were intentional. But intuitively they seem responsive to the personal meaning of the lyrics.

Videotape Excerpt 2**VIGNETTE 4:**

This opening piano duet was c 8 minutes long (session 76, May 7, 2002). Barbara often didn't have enough physical stamina for the sustained piano playing seen in this improvisation excerpt. Compared to other improvisations, the music was atonal, i.e., initially without a discernible tonal centre. I tried to stay away from a defined beat, tonality, melody or harmonic structure in order to not impose my particular musical choices. By keeping transparent in the music, it was my hope that Barbara would hear her sounds as her own musical choices. To my mind, this improvisation was an example of mutual music-making within an egalitarian (anti-authoritarian) relationship. Interestingly, by aiming for transparency in the musical interaction, I had to release aspects of my musical "knowing", i.e., my ability to form and vary musical ideas.

Videotape Excerpt 3

Further reflection revealed that my image of Barbara was one of "woman-child" and that because of her age and the extent of her disability, this image had spiritual dimensions to it. Daniel (1997) explains that the Jungian view of aging is that it's a change process, therefore, "the nature of the therapeutic work is...described as 'soul work' and [is] not the same as the more standard analytic work" (p. 208). Wigram, Pedersen & Bonde (2002) describe aspects of Milieu Therapy in which the therapist's role is to "use an open listening attitude and be available to the client...". The music therapist works to create "a setting where the patient [client] can experience being present and aware, and being seen and heard...music contributes with a spiritual dimension, as musical activities [interactions] are experienced as something that gives nourishment to the soul...(pp. 197-198).

I was very aware that at age 52, Barbara has lived a long time with a severe physical disability. Our work together felt precious. This preciousness necessitated an interpersonal and musical transparency or what could be described as flexible boundaries. Daniel (1997) describes how flexibility was a “notable feature” in her work with older women. She suggests that working flexibly, e.g., not always having weekly sessions or working in a client’s home “...does not destroy the analytic frame: [as she describes] I carried the frame in my head and not in my consulting room” (p. 196).

To Close

Miller & Stiver (1997) acknowledge that discussion of concepts such as “connections and disconnections”, “mutual empathy and mutual empowerment”, “movement in relationship” and “growth fostering relationships” “...may sound overly idealistic, but [they emphasize] that...patriarchal systems have given us a skewed view of relationships, one [a dominant discourse] that leads people to think of relationships as restricting rather than the source of active, creative engagement that enlarges us all” (pp. 56-57). The relationship with Barbara could be described as “negotiating layers of ambiguity.” It was challenging to facilitate a musical relationship with a woman who is physically dependent and without speech. The process was delicate and tenuous; a process of studying subtleties in her responses, interpreting her wishes, discovering emotional nuances, assessing my music and way of being, trying to understand musical interactions a process of, and providing musical and verbal affirmation.

Much of Barbara’s inner life as well as details about her life history remain shrouded in mystery. But getting to know her created a relationship that felt very close, perhaps more so because of its wordless qualities and the fact that we’re women of similar age. Within a client-therapist framework, our relationship over 4 years developed into one of comradeship. “Woman to woman” we met in music and reveled in being alive.

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CHAPTER 6

*From the voice that hurts
to the discovery of song*

Blanc, Cincia

**Editors note: Check for the html
version with all audio files on
MusicTherapyToday.com (November
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Introduction

This is the story of my experience with an autistic boy; to retell this experience, which has been developing for five years, is not easy. Something is always lost: his gaze...smile...and touch. This boy's story (who we shall call F.) and my experience with him has been built up, changed, and rebuilt during this time so that it remains difficult to explain the dynamic aspect of this experience. Yet I have a strong desire to do so. And, to do so in a way that explains the experiences of both my mind and heart.

So, first I shall recount using the existential voice of the here and now when I sat next to him in the sessions and recount my reflections after the sessions, reflections based on research and my own analysis.

About Autism

The definition of autism and its causes have been discussed before in many articles and books so there is little need to look into those specific ideas here today. However, in this part of the paper, I shall recall the most important aspects of autistic pathology to set parameters for F.'s personality traits, behaviours, and life-style in the music therapy relationship. I shall refer only to D.S.M. IV and its appropriate pathology to begin. Later, I shall interpret them in detail.

- DSM-IV Criteria, Pervasive Developmental Disorders 299.00
Autistic Disorder

A total of six (or more) items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):

1. Qualitative impairment in social interaction, as manifested by at least two of the following:
 - marked impairment in the use of multiple non-verbal behaviours, such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

- lack of social or emotional reciprocity
- 2. Qualitative impairments in communication, as manifested by at least one of the following:
 - delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - stereotyped and repetitive use of language or idiosyncratic language
 - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
- 3. restricted, repetitive, and stereotyped patterns of behaviour, interests, and activities as manifested by at least one of the following:
 - a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - b) apparently inflexible adherence to specific, non-functional routines or rituals
 - c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting or complex whole-body movements)
 - d) persistent preoccupations with parts of objects

Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play. The disturbance is not better accounted for by Rett's disorder or childhood disintegrative disorder.

Our First Meeting

I start with our first meeting because it was there that we started to open ourselves up to each other. To do that is one of the most important aspects in the music therapy relationship. We could say that the first meeting establishes this pattern of empathy that lasts to the end of the sessions. And so this small awakening of one person to another in the beginning is forecasted and looked toward in the end session, with its more profound awakening.

[AUDIENCE HEAR SOUND TRACK #1: F PLAYING THE DRUM]

It is spring in 1998. I am working in a classroom at a school near Florence. In the middle of a music therapy session I am giving to the class, the door opens and suddenly a little boy rushes into the class. The teacher runs after him trying to stop him. The little boy runs towards me. Without even seeing me, he takes away the drumsticks from my hands and begins to play as the other students start laughing. He alternately plays single blows to overpowering rolls. During the session, he grimaces with faces of fear with repetitive and stereotyped hand movements between drumming sessions. He dramatically moves his body like a caricature of a hunter, swaying back or forth. It is quite a show. Then his teacher comes in the class to get him. After having finished his performance in another three minutes, F. goes away. I have just meet F. with this beginning.

The sound track you are about to hear now, of course, I recorded much later. However, as is normal with autistic people, he repeated the single blow to overpowering roll rhythm of the first time.

My Proposal and Theoretical Aspects

The following year F. comes to that same school. The remedial teacher has asked to make a proposal of music therapy that would allow F. to integrate himself more easily into the classroom environment. I am used to working with her. The music therapy project begins in the autumn of 1999.

The proposal organisation was the following:

- Frequency: one session a week
- Duration : 2-hour sessions, one hour individual, one hour group. Groups are made up of 4 to 5 classmates who alternate until every classmate participates.

The theoretical aspects of my work come from phenomenology. The phenomenological vision of pathologies has some characteristics I want to mention here. Psychotic disorders present existential ways of understanding the world. To know and understand the patient is to try to understand the patient in his or her world. It is possible to know someone through the empathetic intuition.

To exist is to experience the here and now both subjectively and objectively. Phenomenology also opposes the naturalistic model which is based on a restrictive classifying methodology.

The G.Orff music therapy model draws on ideas from Anthropological Analysis and Phenomenology. Here I shall recall some of its particular aspects.

At the root of all Orff-based models is the concept of “elemental music”.

“Elemental music is defined as the universal and primordial tendency of human beings to make music spontaneously, using the natural rhythms of movement and speech” (Bruscia, 1987).

Elemental music:

1. does not require special or sophisticated training
2. draws on the client’s existing repertoire
3. is an intensely personal experience

Orff also says there is a correspondence between an individual’s musical development and the evolution of music within the culture.

First Music Therapy Session: The Cinderella Song

For the first music therapy session, I brought my guitar, flute, drum, cymbals and various others instruments. F. takes the drum and drumsticks and sets up the same rhythmic sequence which he play throughout the whole session. It is the same sequence you have heard before. He talks to himself, he does not look at me. I am used to being ignored by autistics, I know very well their apparent blindness and deafness to their environment, but at the same time I am always moved by the way they try to show themselves to me. If they love something, they do it intensely and passionately. They really throw themselves into it. After a while, I start singing and he - authoritatively - silences me with his finger to his mouth, saying “Shh! Shh!” repetitively. I am a little afraid, I do not know him well yet. Then he begins to sing a song the words of which are incomprehensible to me. His voice is not clear, the melody and the words confuse me. I try to follow him and, at last, I try to play the melodic line with my guitar. I try to imitate his words too. He likes this. He repeatedly tells me “Go! Go!”. Is this his way of showing himself to me? I am so happy about how our first music therapy session turned out that I plan to work in this song in the following sessions. But - and there is always a “but” – he will never ask me to

sing this song again, nor will he sing for a long time. His song is “Canta Usignol” by Cinderella of Walt Disney.

[AUDIENCE LISTENS TO [TRACK#2] CINDERELLA]

Now I offer you his version of the song; I sing this version because it was not possible to record it. It is easy to recognise that this version is different from the original; the differences come with variations in melody. F.’s song intervals are wider. At the beginning of the song, he sings one octave instead of the song’s third minor; then, he sings a seven-step scale instead of the song’s five. His rhythm is slower and more displaced. In general F.’s song presents an approximate rhythm to the original song with a more spread out, or dilated, melody. We can see...[melodic lines on pentagram played]. It is also possible to discern in this scene the opposition between Anastasia (Bad Voice) and Cinderella (Beauty Voice). This opposition will be frequent in F.’s music therapy sessions.

DSM IV CRITERIA AND F

Now we shall see some diagnostic data about F. from his psychologist’s report. I have tried to compare it with the DSM IV criteria.

1. Impairment in Social Interaction:

- (a) He has appropriate eye-to-eye contact, facial expression, body postures, and gestures only when he is involved in activities which interest him (e.g. drawing, playing the piano).
- (b) He fails to develop relationships with his peers which are appropriate to the developmental level of his age.
- (c) He does not appear to share enjoyment, interests, or achievements with other people (e.g.: a lack of showing, bringing, or pointing out objects of interest to others).
- (d) He rarely shows social or emotional reciprocity . When he does, he uses the facial expressions and gestures of cartoon caricatures he has remembered.

2. Qualitative Impairments in Communication:

- (a) He has no severe development problem with spoken language. However, he does have a limited vocabulary with some idiosyncrasies: possessive pronoun inversion, e.g. he says, “your voice” when he should say “my voice”, also personal pronoun inversion, e.g. he says, “you” when he should say “I”, finally he

uses the third person singular form to speak about himself, e.g. “he’s hurting his voice.”

(b) He is only able to initiate or sustain a conversation with others with difficulty.

(c) He uses stereotyped and repetitive language or idiosyncratic language with special reference to cartoon language and intonation.

(d) He does not engage with his classmates in the spontaneous make-believe play or social imitative play appropriate to developmental level of his age.

3. Restricted Repetitive and Stereotyped Patterns of Behaviour, Activities, and Interests

(a) He has fixed interests: cartoons, comics, Walt Disney movies; he draws very well and often draws animals repetitively (e.g. a mouse).

(b) He tends to perform some non-functional routines or rituals, such as continuously correcting and re-correcting words in dialog bubbles and drawing and re-drawing animals in a manneristic form.

(c) He presents stereotyped and repetitive motor mannerisms, especially hand flapping and twisting, as well as body jumping.

(d) He has no persistent preoccupations with parts of objects.

CONCERNING F’S DRAWING AND MANNERISM

Now I want to add something about F.’s drawings and mannerism. Since my first meeting with F.’s father, it is clear that drawing was something special and important to both of them. We could say it is a sort of language. F. is looked after more by his father, who does not work because of advanced arthritis, than his mother who works as a middle school teacher. F. has two sisters, one younger and one older, both still attend school.

Interestingly, his father has an artistic talent, too; he was an amateur musician who played the piano and guitar before his arthritis. He was also capable of building objects that F. liked a lot. Once, for example, F. was taken to a merry-go-round in the square of his village. After a couple of days, his father built him a miniature wooden merry-go-round to please him.

His father also draws every day; his drawings, which are well done, show significant moments of F.’s day, for example when F. was once enraptured by the merry-go-round. Not all the drawn moments are happy; they all, however, contain a very emotional moment in F.’s day. He has been showing this diary of drawings to F. for years and perhaps this acts as a way of communicating with F. It is interesting to observe that both F. and his father use the same cartoon-style when they draw,

emphasising body and facial expressions in relation to emotional moods . Understanding this relationship F has with his father, it is clear that in F's behaviour, drawings, and graphic mannerisms take on a new meaning. Drawing constitutes a large part of the father-son relationship, it has become a sort of emotional father-son language.

Mannerism has been the object of study for anthropo-analytic and phenomenological psychologists and psychiatrists . According to them, and others such as Binswanger and Jaspers, mannerism is an existential way that we have to understand a disease or pathology rather than to label or judge it. Mannerist behaviour, both in mental disorders and in the artistic sense, has two important characteristics: a model and its repetitive copy.

Let us look at these aspects. The ideal model is necessary when trying to move beyond "fear of living"; it is a mask that represents the emotions – it does not present them. The repetitive and obsessive copying of the model can help a person control the experience of time. Maybe it suspends time. Something that reoccurs infinitely never dies, so the obsessive and repetitive copying of the model saves the person from thoughts of death, and likewise, saves the person from the fear of living (which is a fear of dying).

Mannerism softens one's reality and tames one's destructive instincts to the point that they are more acceptable. The reality "seems" not it is. This regular and repetitive sequencing marks the rhythm of emotions, making them easier to apprehend and feel.

While the traditional psycho-analytical interpretation considers mannerism only as a regressive behaviour, Jasper values and emphasizes the positive aspects of it. Even though, or especially because, mannerism is a voluntary and natural act, it remains different from other acts in life. How is it different?

It is different from them because it is voluntary, natural, but also intentional.

After the First Session

During the second music therapy session, we begin to see the important role the sessions take on in F.'s scholastic life. The music therapy sessions are a point of reference for him, he knows the day of the week I come to school and he waits for me. He is glad when we meet and he is irritated when we don't. The co-operation with

the remedial teacher is going very well. She knows how I work, she knows how patience plays an essential role in my music therapy sessions. I think that having patience is necessary to allow someone to open up and show himself or herself. The patience needed often taken months or even a year.

Patience of when you meet each other, patience of listening to each other, of a focus more to the whole process rather than the contents, patience of building a journey where you both walk together, where you both work hard everyday in the knowledge of waiting for the other, in the knowledge of communicating with each other, in the knowledge of recognizing your differences and dispositions (Mozzanica C.M. 1997)

I must ask myself patiently: What is F. trying to express and communicate during the sessions? Does he play and perform in loneliness? Are we only spectators?

Important Music Therapy Aspects

Cartoons are compulsively present in our sessions, especially Walt Disney cartoons. During the sessions, F. shows two specific vocal and instrumental attitudes. Vocals: he repeats dialogues from Cinderella, Sword in The Rock, Snow White, Fantasia, and Pinocchio. These dialogues are repetitive and they can last the whole session. My attempts to take part in these dialogues are completely useless. F. is very skilled in reproducing both the characters' voices and all the movie sound effects (doors slamming, objects falling down, etc). In these dialogues two specific emotional moods are present through two characters:

1. a weak defenceless character with a little head's voice.
2. an aggressive and overbearing character with a deep and hoarse voice.

In the dialogues during the music therapy session, the same thing always happens: the overbearing character prevails over the weak character and makes fun of him. Concerning the instrumental attitudes of percussion and piano, F uses them in different ways. With the percussion instruments, he mostly plays drum and cymbals, which have a strong intensity, by repeating the same rhythmic sequences. He also reproduces the rhythm and the accents quite well. For example we find this in:

1. "The Hunters Theme" from Prokofiev's Peter and The Wolf
2. The beginning of the first movement in Beethoven's Fifth Symphony
3. The Mickey Mouse March.

With the piano he always plays “The Grandfather Theme” from Prokofiev’s Peter and The Wolf, and Mendelssohn’s Wedding March. He rarely lets me play with him; sometimes I am allowed to perform the “repetitive or imitative answer” described by Orff so that I amplify F’s musical material. It is impossible to improvise with F. or play something else. He does not allow me to play the piano with him, but sometimes we play drums together.

His body is very involved in the performance, emphasizing particular emotional moods. He likes to play alone, as if I were not there.

Now we are going to hear a recording of F. playing Mendelssohn’s Wedding March. Listen carefully to the emotional mood F. creates in the beginning here.

[AUDIENCE HEARS WEDDING MARCH [TRACK #3]]

Hearing this track, it is clear that F. concentrates on the beginning of the March with its repeated notes. The beginning of F.’s March, with its repeated notes, is very triumphal. It seems as if something important is going to happen but ...it does not. And we hear the beginning played triumphantly again and again.

In the famous essay “The Myth of the Eternal Return”, Mircea Eliade speaks about ritual repetition as a characteristic of the primordial archetype; through repetition primitive man enriches his daily experience, making it mystic and religious. Repetition is a special form to actualize the “eternal return” to a mythical time without time. So the repetition of the Wedding March is perhaps a ritual act. F. has some difficulty in finding the correct notes but he plays the piece by always re-beginning at the beginning at some point; he never finishes the piece. He seems to have a strong desire to begin at the beginning with its regal and ritualistic mood.

It is clear that he performs the piece with an approximate melody and a correctly defined rhythm.

After three months, 12 sessions, F. shows the need of a musical structure, vocal or instrumental, that will provide space for improvisation, since he plays the same pieces and says the same dialogues in the same manner. We can also look at F.’s previous experience in the role of Peter in Prokofiev’s Peter and The Wolf. While he was attending fifth grade in elementary school, he played the role of Peter. So

Peter's emotions were familiar and already experienced and felt by him. Peter, and how Peter related to the other characters, was a emotional model for him. To recapitulate:

1. Concerning his playing of instruments: difficulty with improvisation, necessity of a previous musical structure.
2. Concerning his vocal expressions: only spoken language with particular attention to phonetic, rhythmic, intonation aspects; no singing.
3. He always uses his voice to imitate other voices. He absolutely refuses to sing. If someone asks F. to sing he always answers "He can't, it hurts his voice".

Emotion does not have Voice:

Three Events that Changed our Music Therapy Relationship

Now I shall describe three special events that have had an important role in the development of our music therapy relationship. First: One day while F. was playing very low notes on the piano, repeating his already mentioned dialogues, something new happened. He suddenly said, "He is afraid". Surprised, I asked him right away "Who?" and he answered "Geppetto". Now we are going to hear the background music in the mentioned scene.

[AUDIENCE HEARS BACKGROUND MUSIC OF GEPPETTO [TRACK #4]]

While Geppetto is sleeping, the blue fairy changes Pinocchio into a boy. Geppetto built a puppet that, like most puppets, does not move or speak. So, when Geppetto heard some noises in the other room, he became very afraid.

For the first time we have F. playing these low notes on the piano – and – linking them to the emotion of fear. From this moment, F. allows me to take part in his stories. He began to involve me and the remedial teacher as actors; in these scenes, F. allowed me to accompany him by playing different musical instruments. By playing these instruments, I imitated the scene's background noises and the scene's and characters' emotions.

Second: The second important event concerns the song of Adriano Celentano “Emotion doesn’t have a voice”. During group activity, I had asked his classmates to bring a song to school so we could hear them together in a later lesson. I told them that the song should be a song that is important to them, it should tell us something about you.

To my surprise, F. also brought a music cassette, with many songs, to school. He was very emotional, he had difficulty in choosing only one song. But at the end he chose and put in the tape recorder “Emotion doesn’t have a voice” by A.Celentano. The song begins:

I am not able to speak about love

Emotion has no voice.

In these two examples we can observe something important: F. begins to show his emotions to others and he does it through music. Also notice that the song that he chooses for us to hear speaks about emotions and says that emotion doesn’t have a voice. This relationship between voice and emotion requires needs to be explained further.

Umberto Galimberti in his important book *The Body* (1983) says that “the return to the voice is the return to the original image where word and life are called [together] to represent the scene for oneself”. Here, scene, can be understood as the psychic scene, where voice comes before, is more archaic than, the concept of language. Voice is pure and innocent without the veil of language: like the cry of primordial emotions. If voice is the beginning of understanding ourselves in this psychic scene, singing is being, as in the famous *Orpheus Sonnet* of Rilke :

A god can do it. How do you expect
a man to squeeze on through the lyre and follow?
His mind is torn. Where heart ways intersect,
you won't find any temple to Apollo.
True singing, as you teach it, isn't wanting,
not wooing anything that can be won;
no, Singing's Being. For the god, not daunting.
But when are we? And when will he then turn
into our being all the Earth and Stars?

It isn't that you love, child, even if
the voice exploded from your mouth - begin
forgetting, that you sang. That disappears.
To sing in truth is quite a different breath.

A breath of void. A gust in the god. A wind. (R.M.Rilke, Orpheus Sonnets, III)

Now we can think of two different voices: the song-voice and the word-voice. The song-voice has to do with being and presence and is found where emotions are found. The word-voice is not directly related, there remains a distance and delay between words and feelings. Considering this, we can interpret F.'s expression "He can't! It hurts his voice" as F.'s difficulty in getting in touch with, or even contacting, his emotions. The song-voice represents his ego, his bodily being, and it hurts. F. uses the third person singular to distance himself while he uses a cartoon character's voice to get in touch with his ego and emotions. His voice, indeed, hurts this much.

However, F. does begin to show himself through the "He is afraid" of Geppetto and the song of Celentano; here music represents a bridge between word-voice and song-voice. Even if F. still refuses to sing, he is slowly approaching this new experience. In fact he begins to lip-sing the song of Celentano. He puts his cassette on, takes the microphone in hand and moves as a singer on stage. He lip-sings all of Celentano's songs after a while. He knows all the words by heart as he synchronises his lip-singing to when the song begins and ends. F. is moving away from the stage movements of a cartoon character who sings to the movements of an actual singer on stage. Clearly, F. continues to express his autistic behaviours, and also the music cassette becomes a ritual, he wants to hear it every day, all day, over and over, driving his remedial teacher to despair. It is obvious that F. still needs his repetitive rituals to reassure him, above all when he begins to open up.

Third: The third event speaks about falling in love. At the end of middle school F. falls in love with a girl of his class. He writes love-letters to her and he always wants to stay close to her. The girl is a little embarrassed but F. is resolute. At the party on the last day of school, he wants to dance with her. He asks her to dance and suggests the music. This is the first time that F. shows his feelings by himself -- without referring to himself as someone else such as a cartoon character.

The Rediscovered Song

After middle school, F. enrolls in the Art Institute of Florence. The choice to enrol him in an art school has to do with his passion to draw. At the beginning of high school there are many obvious changes; the most significant are different class teachers and remedial teachers. Our music therapy sessions at the high school continue. I act as a bridge from F.'s past experiences to his present one. My role is crucial at this initial stage. Our first meeting in the new school is very funny. When F. sees me, he stands up and bursts out "What's your name?", and immediately embraces me. This is quite emotional for both of us. I think he needed to re-know me and my name in this new situation. F. looks very good, he has grown quite tall. He seems relaxed. His motor stereotypes and vocal echolalia seem to have decreased. His drawing is progressing and continues to have an important role in his ability to express and console himself.

In the remedial class, there are some musical instruments: a keyboard, a drum, a table harp, a bass xylophone and other small instruments (maracas, etc.) In this new context during our music therapy sessions, I can recognize some differences in the way F. relates to music. He is very interested when I play the keyboard, looking at me with great attention. In fact, he wants to learn some songs to play on the piano such as the march from Mickey Mouse, High Hoo from Snow White and the Seven Dwarves, "The dreams are the wishes" from Cinderella. He quickly learns to play these melodic tracks and by himself starts to find new songs to play by ear. When he is not able to find the right notes for the melody, he asks me for help. When I help him, he thanks me by embracing and kissing me. In a short time, he learns to play many songs very well. His father is really surprised because he tells me that after F. comes home from school he is spending more time at the piano. F. does not want anyone to hear him, he shuts the door and plays his songs alone.

Concerning vocal performance, F. still refuses to sing. However, he not only lets me sing now, he also encourages and asks me to sing. Obviously he enjoys me singing now and doesn't "shh" me like before. Our repertory includes Walt Disney songs of course, the already cited song of Celentano, and songs from the Sixties such as the Beatles. He always brings his music cassette with his favourite songs to school and often wants to listen to it but he is less insistent.

In general, F. shows a more integrated and appropriate behaviour to his environment. He still speaks about his middle-school love and continues to draw himself falling in love with her. With all this as background something very special happens.

One day F. begins to sing. It is not a famous song, it is an impromptu song he invented just there. More specifically: it is an improvised song to accompany the xylophone that he is playing. He concentrates on the two notes of D and B. F. repeats these two notes and then begins to sing with a very low voice. He begins:

The Bell Was Ringing
Once upon a time there was
A church near the city
There were many people
Who went to see the bride and groom
Who are in love
There are females
Everyone helped organize the celebration
One day there was the
Wedding of Daniel and Sara
And then the people
Began clapping for the bride and groom
The Bell was ringing.

[AUDIENCE LISTENS TO SONG [TRACK#5] OF THE BELL WAS RINGING]

I am really taken by surprise, it is the first time that I hear F. sing. His voice is still hoarse but it is his voice. Earlier we spoke about the relationship between a voice and the emotions of the ego. I underscored the difference between a song-voice and a word-voice. Here we see how singing, in its purest sense, is indeed a song-voice that allows us to get in touch with the emotions of the ego. The song that F. invented is a turning-point as his song-voice allows him to get in touch with his emotions. He is truly beginning to open up, he has begun to not be trapped in the cartoon world as he begins to understand, explore, and involve himself in other worlds, including his own.

Some remarks about this song that define this song as primitive, according to Curt Sachs' work.

Melody characteristics include:

1. A presence of few repetitive notes (F#/G D B F#/G)
2. The same descending melody structure beginning on a high note and ending on a low note; perhaps it is an octave interval.
3. The approximate intonation between words sung and spoken.

Rhythm Characteristics include:

1. Repetition of simple time sequences.
2. Presence that is near to spoken word.

Sachs speaks of these vocal forms as archaic and primitive, meaning primordial. They would be the first form of human singing. Analysing the words of the song, we see how important the role of love is to F. Most importantly, F. has involved the concept of "Wedding", from Mendelssohn's The Wedding March, which was seen at the very beginning of our sessions together. I think there are two main reasons why F. has focused on "Wedding". The first, and more obvious, concerns his age; F. is now a teenager who is questioning the idea of a romantic relationship. The second, more psychological, comes from his new ability to connect two parts of himself which were separated before, namely two cartoons characters: the Defenceless One and the Overbearing One that were so present in his dialogues. It is as if these two parts dialogue between themselves through the Wedding metaphor.

After he sung the song for the first time, he began to sing other songs happily. For example now we shall listen to him singing Scarborough Fair.

[AUDIENCE LISTENS TO F SINGING SCARBOROUGH FAIR [TRACK #6]]

Conclusions

This all brings us to the end of the speech. I hope that it has been interesting for you and for your work with autistic people. I feel very fortunate to have met F. I have learned much from him. I believe that I have helped him to discover his need to sing and rediscover his voice through singing. My music therapy relationship with F. will continue next year. I think the best way to end is by hearing another one of F.'s songs, this time with the accompaniment of his classmates.

[AUDIENCE HEARS SONG CRUELIA DE MON [TRACK # 7]]

Thank you for your attention.

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Author information

Cinzia Blanc is a musicologist, music therapist and psychologist. She has worked for more than fifteen years with children, youth and adults with disabilities. In the last few years, her work has focused primarily on the age of development, with scholastic, as well as extra curricular aspects. She is an active member of the Centro Toscano Musicoterapia of Florence where she is professor of the two-year course in Music Therapy.

CHAPTER 7

Putting the sad affect of music into words as a way to communicate with the depressive patient?

**Bodner, Ehud; Mazor, Avi; Gilboa, Avi
& Amir, Dorit**

**This presentation has been send as
Powerpoint only.**

Putting the sad affect of music into
words as a way to communicate with
the depressive patient

Ehud Bodner, Ph.D.,
Avi Mazor, M.A., Avi Gilboa, Ph.D.,
Dorit Amir, D.A., ACMT
Bar Ilan University
Music Department, Music therapy MA program
Ramat Gan, 52900
Israel

1

Verbalizing our emotions

happiness fear anger
sadness love
hate



2

Art therapies



3

The impact of Music therapy (MT) on depressive adolescences behavior and brain

- Rock music was found to decrease cortisol levels and relative right frontal activation in depressive adolescences, both while hearing and afterwards (Field et al, 1998)
- MT decreased right frontal activation in adolescences, during the therapy and afterwards (Jones & Field, 1999).

4

The impact of MT on depressive adults behavior and brain

- Healthy adults treated with Bonny Method of Guided Imagery demonstrated decreases in cortisol levels and reported less fatigue and depression (Mckinney et al, 1997)
- Depressed older adults, who were treated by music therapy techniques performed better on tests of depression over 9 month period, as compared to a wait list controls (Hanser & Thompson, 1994).

5

I

The impact of music therapy techniques over distressed adults

- Reminiscence music therapy sessions reduced depressive symptoms in elderly people with dementia (Ashida, 2000).
- Music-assisted reframing intervention was more efficacious than the typical reframing intervention in reducing anxiety, modifying affect, and promoting imagery-vividness (Kerr, Walsh & Marshall, 2001).

6

The impact of music therapy in grief therapy

- "Music in grief therapy seems particularly useful for those who have difficulty finding words to express emotions. (Kirmayer & Robbins, 1993).
- Playing the piano and vocalizing during the music therapy process may help to express, in an unconscious way, parts of personality that were suppressed since childhood (Smeijsters & Van Den Hurk, 1999)

7

MT clinical themes about the therapeutic change in Grief Therapy

- " Music therapy is able to work at a psychotherapeutic level in persons seemingly unable to be influenced by conventional psychotherapeutic-methods" (Jochims, 1992)

8

Alexithymia

•a=lack

•lexis⇒word

thymos=emotions



9

Learning emotions through social
referencing



10

Psychopathologies characterized by Alexithymia

- Psychosomatic
- Patients with history of child abuse
- PTSD patients
- Patients with eating disorders
- **Patients with major depression**



11

Can music mitigate alexithymia in major depressives?



words



12

Possible contributions

- Very few studies have concentrated on the clinical mechanisms that enables the efficacy of music therapy with depressives
- No study has yet addressed this issue of verbal expression in major depressives through quantitative research methods.
- No study has yet examined the emotional sort of the music that may help the depressive patients to cope their illness.

13

The Turned-in anger conceptualization



14

Major Depressives prefer sad facial expressions



15

The vicious cycle of depression

Can this viscous cycle be broken?

Elaborated self and other negative schemas

Attention is captured on sad contents negative schemas

Heightened responsiveness to negative contents

16

Obstacles on the verbal communication between patient and therapist

- Passivity
- The victim role
- resistance to change
- compulsive tendencies



17

The impact of music

- Will sad music enable the major depressive patient to be more communicative than other forms of music?



18

Major assumptions

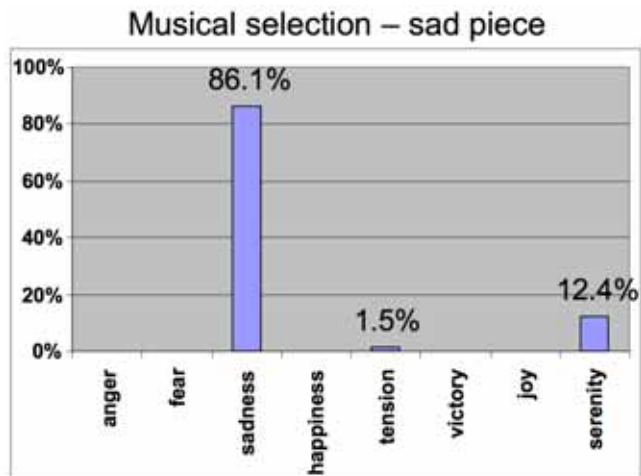
- Depressives would be less alexithimic in response to sad music as compared to any other affective tone in the music
- Non-depressives would not be more verbally reactive to a sad tone in the music

19

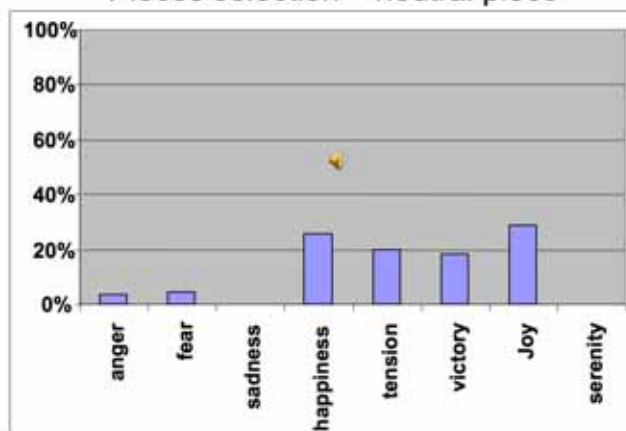
Participants

no hearing problems, full language control

| | |
|---|---|
| Major depressives (n=14) 9 women 5 men 44.9±15.2 | Healthy controls (n=31) 16 women 15 men 30.5±8.6 |
| Patients participated while being in psychiatric hospitalization | Healthy controls participated while being students with no psychiatric history |



Pieces selection – neutral piece



| S | Musical piece | E | % |
|---|--|--------------|-----|
| 1 | Prokofiev, Sergey, "Finale: molto vivace", 4th move. From: Symphony no. 1, op. 25 D major (opening) (Classical Symphony) | happy 😊 | 90 |
| 2 | Debussy, Claude. Prélude à l'après-midi d'un faune (excerpt from) | neutral 😊 | <30 |
| 3 | Stravinsky, Igor. Le Sacre du printemps (The Rite of Spring) - Part 2, "Introduction" (opening) | fearful 😬 | 80 |
| 4 | Handel, "Water music", Air from suite no. 1 in F major | neutral 😊 | <30 |
| 5 | Stravinsky, Igor. Le Sacre du printemps (The Rite of Spring) - Part 2, "Glorification of the Chosen Victim" (opening) | anger 😡 | 78 |
| 6 | Villa-Lobos, Heitor. "Allegro preciso," 1st. move. From: Concerto for Guitar and Orchestra. | neutral 😊 | <30 |
| 7 | Beethoven, Ludwig van. 2nd move. Symphony, no. 3, op. 55, Eb major (opening) (Eroica) | sad 😞 | 88 |

42 emotional items of :

| | emotion | Put an X if in major depression |
|---|-----------|---------------------------------|
| 1 | despair | |
| 2 | sadness | |
| 3 | hope | |
| 4 | love | |
| 5 | emptiness | |
| 6 | envy | |

25

42 items of emotions:

| Agreement percent to MD | Depressive score |
|-------------------------|------------------|
| 76-91 | 7 |
| 63-73 | 6 |
| 37-62 | 5 |
| 22-33 | 4 |
| 8-19 | 3 |
| 3 | 2 |
| 0-2 | 1 |

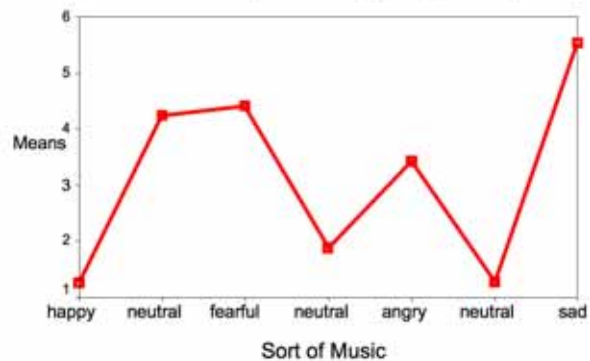
While listening to music...



| | emotion | Put an X |
|---|-----------|----------|
| 1 | despair | X |
| 2 | sadness | X |
| 3 | hope | |
| 4 | love | |
| 5 | emptiness | X |
| 6 | envy | X |



Mean depression of the words selected in each of the 7 pieces by all participants



Mean depression of the words selected in each of the 7 pieces by all participants

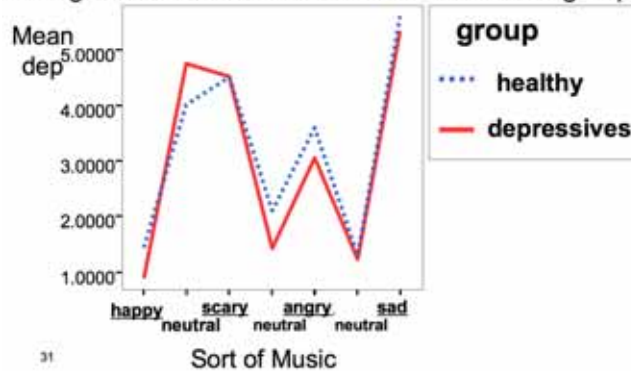
| Emotion | Mean | SDs | N |
|---------|------|------|----|
| happy | 1.27 | 0.52 | 44 |
| neutral | 4.19 | 2.23 | 44 |
| fearful | 4.51 | 1.57 | 44 |
| neutral | 1.91 | 1.64 | 44 |
| angry | 3.42 | 1.14 | 44 |
| neutral | 1.30 | 1.32 | 44 |
| sad | 5.49 | 1.93 | 44 |

A Manova for Repeated Measures for comparisons of depression scores for each piece to the sad piece - all

| Pieces comparisons | df | F | Sig. |
|--------------------|-------|--------|-------|
| happy vs. sad | 1, 43 | 193.75 | 0.000 |
| neutral 1 vs. sad | 1, 43 | 15.36 | 0.000 |
| fearful vs. sad | 1, 43 | 6.32 | 0.016 |
| neutral 2 vs. sad | 1, 43 | 78.37 | 0.000 |
| angry vs. sad | 1, 43 | 54.61 | 0.000 |
| neutral 3 vs. sad | 1, 43 | 130.55 | 0.000 |

Mean depressiveness associated with the chosen words by each group

No significant differences were found between groups



31

Major depressives level of verbal responsiveness to music

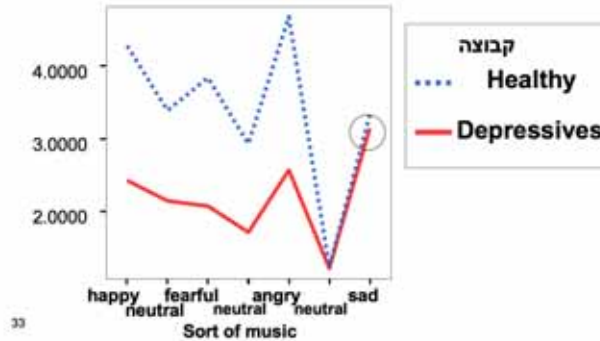
- Do major depressive patients use less words than healthy controls to describe their emotional experience in response to some orchestra instrumental pieces of music?



32

Means of verbal choices by group

Compared to normals, depressives are alexithymic in response to all but sad emotion in music

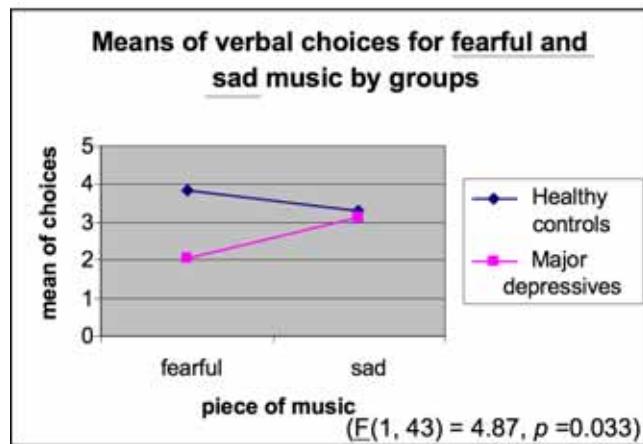
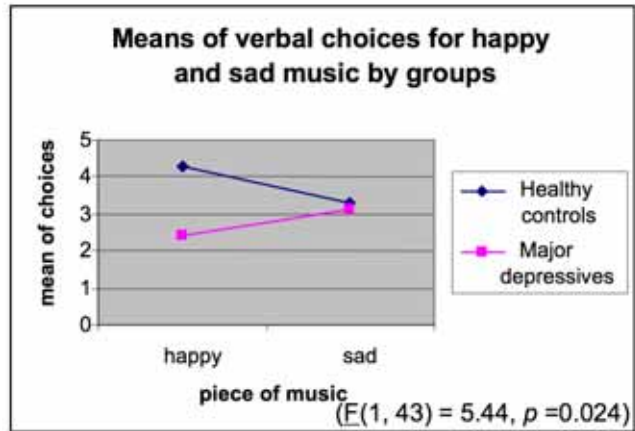


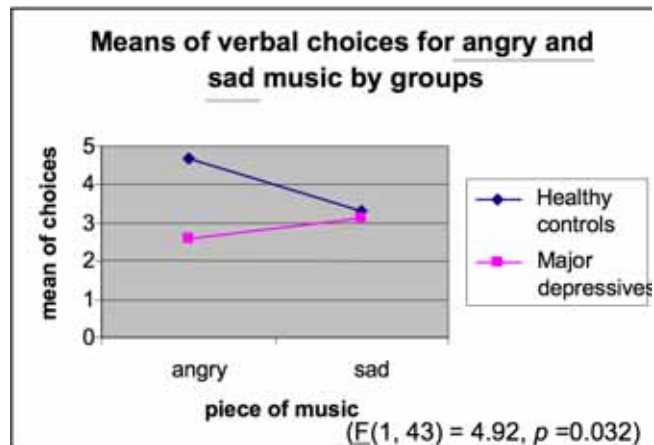
Verbal responsiveness to sad music among Major depressives

- As compared to themselves, will major depressives be less alexithymic in response to sad music as compared to any other affective tone in the music?



34





Major findings

- Major depressive patients can overcome their alexithymia and show normal emotional naming
- This process occurs as a result of listening to music
- It happens only when they listen to sad music.

26

Clinical Implications

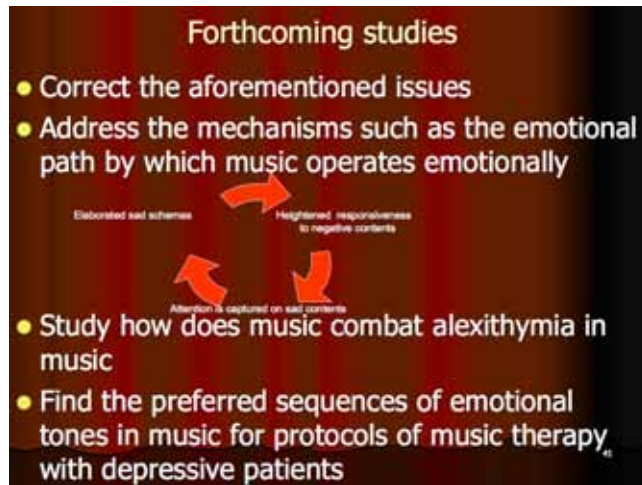
- It is important to establish a connection to these patients on their emotional level i.e. sad.
- The emotional quality "put" in music may improve these patients ability to communicate their feelings.
- The use of sadness in music, which enriches the patient's verbal expression may assist the music therapist in obtaining better results from the patient

39

A few points worth addressing

- Flat affect or alexithimia?
- The impact of different phases of treatment of the patients in the study?
- The influence of differences in procedure between healthy and major depressives?
- The influence of sequence?

40



CHAPTER 8

The effect of music on patients undergoing general anesthesia

Bogopolsky, Helena

Music Therapist, Jerusalem, Israel

Editors note: Check for the html version with all audio files on MusicTherapyToday.com (November 2005)

Introduction

For the last two years I have been researching the effect of music on patients undergoing general anesthesia. While we are still in the process of collecting results and therefore cannot report conclusively on them, we have discovered some intriguing and important data in the process.

My personal interest in researching the effect of music on patients undergoing general anesthesia is motivated by the facts that :

1. I personally underwent an operation when I was 12 years old and it was a traumatic experience for me;

2. as I was trained both in music, music therapy and in nursing, I am interested in the field of medicine and its connection to music;
3. it is my strong belief and professional experience that aspects of the body and mind are interconnected;
4. music has a strong influence on both the mind and the body.

I spent many months searching for an anesthesiologist who would agree to collaborate with me in this research. I encountered a lot of skepticism. The idea of a music therapist donning mask and robe and entering the operating room was unusual. The emotional well-being of the child undergoing surgery - was not something most of the surgeons tended to deal with, due to their emphasis on the clients' physical being.

I was fortunate to find Dr. Kadari from Hadassah Medical Center in Jerusalem, who was the first anesthesiologist to allow parents to enter the operating room with the child, and stay up to the point when the child falls asleep. This simple and natural way of helping both parents and child to cope more easily with the trauma of an operation (even a simple one) is now an accepted practice in Israeli hospitals.

I would also like to add a point of clarification regarding the presentation itself. The presentation will focus on physiological, bio-chemical and behavioral aspects of music therapy during anesthesia. Unfortunately, and despite earlier references, we are not yet able to report on neurological aspects.

Hearing and Memory Under General Anesthesia

In the last few years, research has shown that people are able to hear and, afterwards, report what they heard while they were subjected to general anesthesia (McCarron and Bonny, 1984).

How would you feel if you were a patient undergoing surgery and heard the following words while lying anesthetized in the operating room?

Just a moment! I don't like the patient's color. Much too blue.

Her lips are very blue. I'm going to give a little more oxygen. . . .

There, that's better now. You can carry on with the operation.

(Levinson, 1965:544)

FIGURE 1.



Surgical patients who have been administered general anesthesia are not EXPECTED to be aware of events during anesthesia, and they are not EXPECTED to have any post-surgical memories of events that occurred during anesthesia. However, despite these expectations, research (Levinson 1965, Gurman 2000) has shown that in many cases high level auditory processing (as is necessary for music perception) still exists for at least some patients undergoing general anesthesia. In addition, research shows that even if the patients cannot recall exactly what

occurred in the operating room, evidence of their experiences comes up in implicit memory tasks. (Gurman 2000).

The implications of such reports are serious indeed. Patients may be at risk of psychological trauma that they may not even be aware, or know the source of. In fact, research shows 80 % that of those patients who are aware during general anesthesia show symptoms compatible with Post Traumatic Stress Syndrome (Cundy and Dasey, 1996: 143). So, if nothing else, simply wearing headphones and being exposed to music rather than to stressful comments during the operation could have beneficial results.

However, we hypothesize that the administration of music during anesthesia has much deeper effects. These effects are related to music's ability to influence physical and psychological states.

Review of Literature

Discussions about the influence of music on depression and pain have been around since at least the beginning of the 1800s. Some stories even go back to biblical times. In those days, there were no technological means to measure or standardize experimental results. Over the years we have witnessed vast improvements in science and technology, but we still do not know exactly what effect music has on the human body.

So What Do We Know Today?

We do know the following effects which music has on the human body:

PHYSIOLOGICAL AND PSYCHOLOGICAL ASPECTS:

FIGURE 2.

Psycho-Physiological Aspects

Music affects the Limbic System



Pulse, Blood Pressure and Breathing Rate

Pain Perception and Sensation

Music Reduces Stress Levels



- ***Evokes Conditioned Relaxation***
- ***Lowers Levels of the Cortisol Hormone***

First of all, we definitely know that music affects the limbic system which regulates deep emotions and many involuntary physical operations and reactions: Pulse & blood pressure (music can change the rhythm of our body, such as our heartbeat and breath rate).

Second, music may alter pain perception and pain sensation.

- One explanation of music's ability to influence pain perception is that listening to music coaxes the body to release its own **endorphins**, which are an endogenous healing mechanism similar to morphin.

Music also assists in reducing stress levels:

- Music evokes conditioned relaxation in much the same way as the sound of a dentist's drill evokes conditioned nervousness.
- Patients who were given distressing information about requiring surgery had their stress levels reduced by listening to relaxing music. The reduction in stress was evidenced through reduced levels of cortisol. (Miluk et.al 1994)

Hypothesis: In light of the factors and influences mentioned above, it is reasonable to assume that music can provide a major contribution to reduce stress levels.

EFFECTS OF MUSIC ON PATIENTS UNDER ANESTHESIA:

It is therefore not surprising that a number of studies have shown positive effects of music on patients under general anesthesia (Lehmann, 1985; Furlong, 1990; Aldridge, 1995; Spintge, 1985; Gozal & Gozal, 1998; Nilsson, 2001). Although some research has been done to better understand the effect of music on patients undergoing general anesthesia, there are still many questions left unresolved. Firstly, what are the tests or diagnostics available to measure emotional stress directly?

Secondly, would music provide the same beneficial effects on children undergoing general anesthesia?

STRESS FROM HOSPITALIZATION

As we know, hospitalization can be a traumatic experience. Robertson and Bowlby (1952) researched the effects of hospitalization on children under the age of four. Observations revealed that even those who were hospitalized for short periods underwent the following stages:

- Protest (due to anxiety at being separated from the parent)
- Despair
- Denial (the latter two serving as defense mechanisms)

It appears that even after the 1950s, when parents were permitted to remain in the hospital at the child's bedside, the same stages could be observed. The very experience of being cut off from home, and the traumas of hospitalization, surgery and treatment, sufficed to create such reactions. (Sekeles, 1996).

As we mentioned before, surgery and anesthesia, as intrusive medical procedures, are physically stressful and can be measured scientifically. However, emotional stress due to hospitalization is more difficult to define and to measure. Nonetheless, doctors will admit that reducing levels of emotional stress is also an important factor in helping to guide the patient to a healthy recovery.

According to Dr. Kadari's personal experience, children's emotional states, whether stressed or relaxed, are the same when they enter the operating room as when they leave. The child's initial emotional state will strongly influence his pain perception and recovery after operation. It is well known that entering the operating room can be a very difficult task for a child. Children are often afraid and sometimes even cannot cooperate with the surgeon or the anesthesiologist. Surrounded by unfamiliar faces and objects, children often enter the room scared and nervous. It is therefore important to intervene in this process. One of the better methods of intervention is music therapy.

As a resident music therapist in the children's surgery department of Hadassah Medical Center in Jerusalem, I have often witnessed the positive effects music has on the emotional state of post-operative children. I can tell you about one nine-year-old girl who underwent music therapy in the pre-medication process. Instead of entering the operating room shy and reserved, she leaped in singing and full of joy. These encounters with the children before and after surgery gave me the incentive to research the effects music might have during the process of the surgery itself.

Hypothesis: Given all of the above I hypothesized that the use of music therapy for anesthetized patients undergoing surgery can help to reduce levels of emotional stress.

HOW TO MEASURE EMOTIONAL STRESS

One of the first major difficulties I faced was how to measure the emotional stress in children. Since in the world of medicine only measurable results are valid, finding a measure for emotional stress can be quite a challenge. In addition, once the measure is defined, it has to be standardized which leads to additional problems. We decided upon measuring the level of Cortisol known as "the stress hormone".

Since we could not use blood tests for this research because of the Helsinki committee's limitations on intrusive procedures, we opted for measuring Cortisol levels in saliva (Vining RF, McGinley RA1987)

Research Design

In order to achieve standardization , my research concentrates on relatively simple eye operations . I investigate the effects of music on patients undergoing general anesthesia for eye surgery by comparing both the quality of the post-operative behavior and the biochemical levels of Cortisol - the stress hormone.

I begin by meeting with children ages 6 to18 in the preoperative preparation program. I let them know that they have the option of listening to music during the operation. If the child shows interest, I obtain written permission from the child, their parents and the medical staff. The child then brings their personal choice of music which was pre-selected in an interview before the operation.

During the operation, I supply the child with a set of specially designed earphones that do not interfere with the surgery. The music is turned on and adjusted to a level that does not exceed 65-70 dB (typical for experiments in music cognition).

In order to measure the effects of the music and to measure stress levels before, during and after the time of the operation, the saliva test is taken 3 times:

- 1.** First, one day before the operation.
- 2.** Second, immediately before anesthesia
- 3.** Third, upon awakening from anesthesia after the operation .

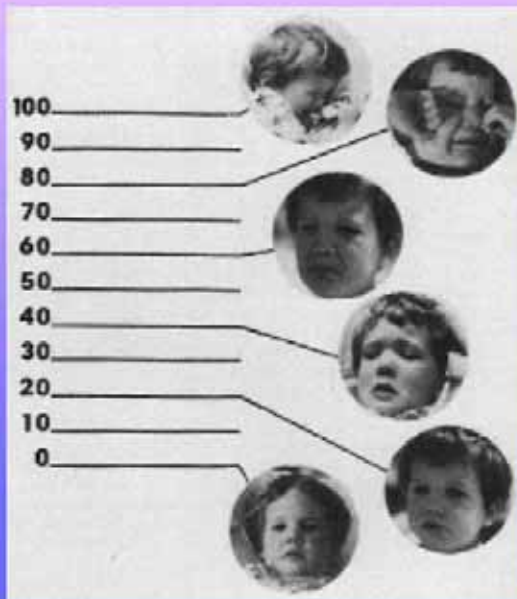
In addition to the saliva test, we used two additional scales in order to determine the patient's state.

As you can see on the 4-point Watcha Agitation Scale:

4-Point Agitation Scale – Watcha

| | |
|------------------------------|----------|
| Relaxed | 3 |
| Crying but consolable | 2 |
| Crying inconsolably | 1 |
| Restlessness | 0 |

Oucher Visual Pain-Scale



SUBJECT DEMOGRAPHICS

The research population included children between the ages of 6-18. This age range was selected so as to enable me to communicate with them freely. The children came from 4 different cultural backgrounds:

- Secular Jews
- Secular Arabs

- Religious Jews
- Religious Arabs

The patients' languages included Hebrew, Arabic, English and Russian.

In the case of Arabic speaking children, I invited the parents to assist in translation. In the case of Hebrew, English and Russian speaking children, I personally communicated with the children myself.

HOW WAS THE MUSIC CHOSEN?

My initial thoughts were to choose relaxing music. This can range from the soothing sounds of the ocean waves to the rhythmic echoes of dolphins and whales, to a particularly mellow jazz or classical piece.

After listening to the many possibilities of sounds (waves, dolphins etc.), I realized using “natural sounds” may be problematic.

1. First, they did not possess any clear holding structure.
2. Second, they were not sounds that children were used to hearing at home.
3. Third, there was no human voice attached to the sounds to provide support and a connection to reality.

So, I came to the conclusion that “natural sounds” may not be suitable for this specific situation. Given that hospital settings can be very stressful and filled with tension, I believe it is important for each patient to find music that gives him comfort and support. So, when choosing what music to bring, I believe that it is important to take into account the cultural and personal background of the patient. The type of music a patient might choose can vary significantly depending on the patient's background and personal tastes; it is important to let the patient choose what music best suits them and makes them feel most comfortable. Therefore, rather than applying the principle of an “International Language of Music” I emphasized the patients' own personal preferences.

I suggested that each child bring music they love, music that I assumed would evoke feelings of comfort and security. Before I began my project, the nurses would tell children to bring a favorite toy or stuffed animal that would greet them after their operation. However, music could both greet them when they woke up and accompany them through the entire procedure of pre-, intra- and post-operation; just like Tamino who played upon the flute while braving the dangers of fire and water in Mozart's "The Magic Flute".

In this way, music serves as a "transitional object" (Winnicott, 1971), a tool used to help overcome unpleasant feelings and loneliness.

SO WHAT TYPE OF MUSIC WAS CHOSEN?

- **Secular Jewish:** boys tended to prefer rap music in Hebrew and English whereas girls from this sector preferred local and international pop music.
Boys - Rap
Song - Moving with the Bass
Artist - Subliminal and the Shadow
Lyrics by The Shadow, Subliminal, Chuck Dorfman, Buskilaz
Album – The Light and the Shadow
Release Year: 2002
Excerpt

Girls - Pop
Song - Diva
Artist - Dana International
Lyrics by Yoav Ginai
Music by Tsvika Pik
Album – Diva: The Collection
Release Year: 1998
Excerpt
- **Religious Jews** selected popular Hebrew music incorporating religious and biblical texts, which is especially geared towards this population.
Song – Ani Maamin (I believe)
Artist –
Lyrics by Rambam (Rabbi Moses Ben Maimon)
Native music
Excerpt
- **Secular Arabs** of all ages chose popular Arabic music.
Arabic Pop –

Song – Drunk Hanna (Hanna el-Sakran)

Artist – Fairuz

Lyrics by Elias Rachbani

Music by Rachbani Brothers

Original Song

Year – Unknown (probably 1973)

Excerpt

- **Religious Arabs** chose recorded chants of the Koran and specifically requested not to listen to anything else.

Kuran Suras

Sura Ihlas - Quran 112

Artist – Abdul Samad

Album – Abdussamed - The Best

Excerpt

Note: to listen to this music got to <http://www.musictherapytoday.com> and search for Helen's article in the November 2005 issue

As we have just witnessed, some of the common factors in the musical selection were:

- Familiar element
Children selected music that was listened to at home
Children looked for something to hold onto and find comfort in when in an unfamiliar and scary situation.
- Type of music
Most children listened to either Rap, Pop or Religious “Rock”: it is important to note that these are all far from being classical lullabies and often have a fast tempo and loud vocal and instrumental parts.
- Vocal music
In almost all cases, music had a human voice. It is possible that the human voice has a special capacity to connect.
Religious children would often find comfort when listening to religious texts
- Tempo

Indeed, the choice of fast tempo reminds us of ecstatic healing rituals in which the healer is using music with a characteristic acceleration in order to overcome pain and anxiety. (Sekeles, 1996).

- Rhythmic element

Ralph Spintage (Professor of Music Medicine and Doctor of Anesthesiology) emphasizes that rhythm is the main factor of stimulation in music. When he asks his patients what they feel when they are listening to music during an operation, they say that they escape from the current situation to the "discothèque".

Conclusion

To conclude, today we have talked about some of the many helpful psychological and physiological effects of music. These aspects convinced me that music could play an important role in helping patients at risk of emotional stress.

Initially, I thought that measuring the effects of music would be simple. I would provide patients with music, measure levels of stress, and we could immediately measure the benefits. It turns out the process was much more complicated than that. Factors such as the depth of the anesthesia, levels of emotional stress, standardizing and measuring results have all added to the complexity of the experiment. However, I feel that, as in music, the process of discovery itself is important, and not just the results.

What we have seen, based on our other measures, has been very positive. When measured on the 4 point agitation scale, patients have consistently measured at either the "Relaxed" or the "Crying but Consolable" levels. However, these results still need to be validated due to the absence of a control group.

As I have previously mentioned, due to technical challenges in measuring levels of emotional stress, we are still in the phase of testing saliva and are eagerly looking forward to the results.

We are continuing with our research and look forward to advancing to the next stages.

Also, on one final note, I would like to extend a warm thank you to my teacher, my advisor, and a person that has given me much support during my research, Dr. Chava Sekeles. Thank you all for your time...

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CHAPTER 9

*Measurement strategies in music
therapy clinical practice for general
medical settings*

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Abstract

Good clinical practice informs music therapy efficacy research, as music therapy efficacy research informs good clinical practice. This symposium is a forum for discussion of the varied categories of medical and/or behavioral measurement instruments and procedures clinicians in general medical settings are examining in their practice by medical unit. Due to a dearth of research studies on music therapy efficacy in many general medical settings, clinician presenters in this symposium will present the strategies they have developed or are examining for patients on specific units.

Measurement Strategies in Music Therapy Clinical Practice for General Medical Settings

Good clinical practice informs music therapy efficacy research in initial examinations of the appropriateness and benefit which patients may receive from music therapy services. This symposium is a forum for discussion of the varied categories of medical and/or behavioral measurement instruments and procedures clinicians in general medical settings are examining in their practice by medical unit. In acute care settings goals for patients typically fall into categories of stabilization, improvement, acceptance, pain management and/or anxiety or stress reduction. There is growing recognition in the medical community that health factors are affected by psychosocial factors. However, music therapy clinicians are often expected to demonstrate correlations between medical measurement procedures and music therapy outcomes. Third party payers require demonstration of benefit. Further complicating the clinicians' responsibilities is the common practice of reimbursing services in 15-min increments.

"Benefit" is an amorphous concept. The Random House College Dictionary (1979) defines "benefit" as "anything that is advantageous or for the good of a person...from 'bien fait' (good deed) in Medieval English and French" (p. 126). In order to demonstrate benefit in acute care settings, clinicians need to (a) assess patient needs and strengths, (b) treat the patient within the assessment process, (c) develop a data profile to demonstrate benefit, and (d) analyze and present the data collected. Multiple factors impact the type of music therapy services patients receive. These include patient diagnoses, patient and therapist schedules, duration of stay on units and varied psychosocial and physiological needs of individuals. In

response to the exigencies of the acute care setting, the music therapist must adapt the assessment process to the factors related to delivery of services by unit.

The analysis of benefit varies according to population, unit and individual strengths and needs. Standard medical instrumental assessments, e.g., blood pressure, pulse rate, degrees of flexion/extension, etc., present a common ground for observation of benefit when the measurements show clear patterns. Standard psychosocial measures administered by nursing, psychological or social work staff may serve as the basis of comparison for behavioral assessment and observations developed by the music therapist. It is advantageous for the patient if the music therapist can demonstrate relationships between the three categories of measurement procedures. Medical professionals are highly trained in the use of standardized measures. They tend to trust those measures over behavioral observation techniques in which they have not been trained. Particularly, because induction related to the behavioral observation is often considered questionable because it appears as “not absolute.”

In order to address concerns of medical staff, the design of the music therapy assessment instrument should include: (a) patient needs and strengths, (b) typical behavioral indicators of pain, anxiety, depression and empowerment, (c) typical behavioral indicators of improvement or stabilization, (d) standardized medical measures in use on the unit, and (e) issues related to unit management, e.g., time of day for service delivery which may affect patient performance. Although the therapist collects these varied data types, it is important to present data so that the information can be understood by other professionals in minimal periods of time. The instrument is designed to collect more data than is necessary to demonstrate benefit. Presentation of data needs to show benefit, but due to variability among patients, the data can be quite different. Data presentation should identify relationships between medical goals and music therapy services. It is desirable to identify outcomes by stating specific medical goals and to correlate those with behavioral observations during musical activities. For example, if the nurse tells the therapist that the patient’s eyes do not approach mid-line and following introduction of the music therapist to the patient, the patient maintains eyes at mid-line for over 15 minutes; then it is best to report patient response in terms of eyes approaching mid-line. In working physical rehabilitation, music therapists often note the degree of hand extension, its frequency and duration, during activities with musical instruments. The music therapy setting provides patients with unique opportunities to demonstrate their strengths and potential for improvement.

The process of assessing patients’ needs requires the therapist to: (a) focus on patient strengths, (b) listen for patient responses, (c) shape positive responses through reinforcement, and (d) address patient concerns relative to achievement of

sense of control and strengthening relationships with loved ones. We begin with the patients' strengths by introducing ourselves, looking at the patient and noting personal appearance, noting whether the patient is doing something, e.g., holding a book, magazine, etc., and then asking the patient about the item(s), and, finally, describing what services we offer. Procedurally, we observe any behavioral indicators of pain, anxiety, depression, etc. We note positive verbalizations about self and others. We present the patient with a simple choice related to our services. We analyze specific behaviors related to unit goals.

The assessment process is both active and passive. Above I described the initial active components. We must also "listen" for patient responses. Is the patient singing, humming, or attempting a response? Is s/he showing a release of tension? Is the patient oriented to the therapist? Is the patient smiling? Is s/he tapping, clapping, and/or moving in rhythm? Is the patient requesting something?

As we "listen" for responses, we often note a lack of independent responses. Patients will respond to directives or prompts, however, spontaneous independent responses are infrequent. In order to shape positive responses, it may help to make a statement or ask a question of the patient relative to music. As you listen to the response, acknowledge it. Note informational and negative verbalizations as well as positive verbalizations. In an acute care setting, informational verbalizations – whether personal or situationally related – are positive steps toward personal empowerment. In order to address patient concerns related to a sense of control over one's life, present the patient with choices relative to music therapy services and to the music itself. Sometimes it is best to present this in a relatively objective way, such as presenting the patient with a typed menu of services, rather than attempting to engage them in verbal choices immediately. No matter the format, wait for the patient's response, it may be delayed. (Often patients in hospitals have stopped making decisions, so even simple decisions take time.) Interpret the response if it is unclear, and then ask if you interpreted it correctly. This is especially important with patients who are nonverbal due to a tracheostomy or other intervention. Interacting with the patient as if you expect a response may be all the patient needs to begin responding even if the modality must be developed in terms of physical signs for yes, no and maybe responses.

Due to the intense experiences of vulnerability which patients in medical settings have experienced or are experiencing, it is important to address patient concerns related to strengthening relationships. The therapist can offer services which could be presented later to the family, e.g., song writing. The therapist can reinforce positive expressions about family members. S/he can reflect on the statements and

musical experience. If the patient is nonverbal, the therapist can discuss with the patient shaping questions so that they may be answered with a yes, no, or maybe.

One of the difficult situations a music therapist encounters especially during the initial assessment process involves addressing patient refusal of services. How do we say, “Okay”? We need to acknowledge the patient’s decision. We also want to shape alternative responses. In an effort to empower a patient, we do not want to be paternalistic. Some strategies include: (a) placing the response in the perspective of the present, (b) offering a less intensive experience, e.g., listening to a Walkman, and (c) saying when you will return to see the patient and pick up the Walkman.

The design components of behavioral instruments for general medical settings have both common and unit unique components. Appendix A shows a model for an acute care physical rehabilitation unit. The primary components of an assessment are: (a) a section on patient needs, strengths and preferences, (b) a section on measures related to the diagnosis/diagnoses, (c) a section on communication including verbal and nonverbal interactions, (d) a section on characteristics of note, and (e) a section for comments and anecdotal notes. As you will note in the sample assessment form, those sections are not discrete. They also do not occur in the order presented above. The problems that the therapist encounters shape the process of data collection. The first step on acute care physical rehabilitation is to establish communication, so that is reflected in the format. Responses during the introductory period are key to comparisons during musical activities. Information relative to whether the patient participates despite demonstrating pain indicators is important. Communication is at the heart of therapy. It is through the communicative process that we understand a patient’s strengths.

Measures related to the diagnosis or diagnoses vary by individual as well as by unit. For example, therapists working a stroke unit will meet patients with varied presenting problems. Therapists working a dialysis unit will meet patients with many common symptoms. With this population, measuring blood pressure prior to and following the session would be common practice. Allowing patients to share their life stories with us through music allows us to learn patient strengths and coping strategies. This can be condensed on an assessment form that allows for multiple categories of responses. The condensation is obviously important because we want data collection to enhance music therapy services and provide a demonstration of benefit for the patient. I wish to encourage dialogue among all of us so that many patients in medical settings can be served by music therapists.

Appendix A

MUSIC THERAPY ASSESSMENT DATA SHEET

Patient Name: _____ Date & Time of Session: _____

Diagnosis/Diagnoses: _____

Cautions: _____

Communication/Verbalizations:

Prior to Music Intervention (Note duration as Short, Medium or Long)

Positive _____ Negative _____ Informational _____
Attempts _____

Orientation to Therapist _____
Requests _____

Comments:

During and Following Music Intervention (Note duration as above.)

Positive _____ Negative _____ Informational _____
Attempts _____

Orientation to Therapist _____
Requests _____

Comments:

Patient Requests: Style(s)_____ Pieces _____
Artists _____

Decisions: Independent _____ Choices Specified _____
Prompted _____

Comments:

Pain & Fatigue Indicators: (Note duration and severity if appropriate.)

Comments _____ Tensing _____
Spasms _____

Eye Squeezing _____ Teeth Clenching _____
Breath _____

Fatigue/
Other _____

Musical Responses: (Note abbreviated title if applicable.)

Singing _____ Humming _____ Attempted S/
H _____

Tapping _____ Clapping _____ Moving in
Rhythm _____

Instrumental Performance _____ Listening _____
Relaxing _____

Comments:

Measures related to Diagnosis/Diagnoses:

Movements Requested:

Related Topographies:

Scalar Mea-
sures:

Repetitions: _____ Duration(s): _____ Verbaliza-
tions: _____

Comments:

Intervention Strategies & Rationale:

Patient Strengths:

Characteristics of Note:

Signature: _____

CHAPTER 10

*“Thank you for the music -” an
exploration of music therapy for a*

*child with severe
psychosomatic
symptoms*

Carter, Emma

I would like to present to you the role that music therapy played for a child who presented with severe psychosomatic symptoms and to show how he was able to use music as a means of communication at a very difficult time. I will discuss the case in depth, illustrating this with video extracts and then examine some questions about the implications of music therapy in this case. In particular I want to explore what it was about the medium of music and the therapeutic relationship that developed between us that enabled him to make progress.

Elliot, an 8 year old boy, was admitted to the Croft Children and Family Unit in Cambridge where I have worked since 2000. The Croft is an inpatient psychiatric unit which provides assessment, diagnostic and treatment work for children with severe psychiatric disorders and those with behavioural and psychological difficulties. Children are admitted residentially with their families and generally stay for four to six weeks. In Elliot's case he stayed for almost six months.

Prior to his admission Elliot had complained of abdominal pains and was displaying highly anxious and low moods. He had been thoroughly investigated on a paediatric ward but no physical cause for the pain had been detected. He nevertheless continued to suffer and had actually stopped attending school. He was then referred by the neurological department for an outpatient appointment at the Croft to make a psychiatric investigation, after which his behaviour dramatically deteriorated. He was then immediately admitted to the unit as an inpatient. It is important to note at this point that Elliot had been developing within normal limits prior to his illness.

I first encountered Elliot a couple of days after he had been admitted. He was crawling along the ground, making noises that can be only described as animal-like. These sounds or sobs of anguish continued through all his waking hours and seemed to come from deep within him and were incredibly disturbing to hear. He did not walk but rather crawled, dragging his body along the ground, taking what must have seemed like an eternity to make a short distance. He continually sucked on his sleeve and hid his face at all times by holding a flannel, cloth or the hood of his sweatshirt over it, as if he could not bear to look at the outside world or let it see him. He communicated only by shaking or nodding his head and also by writing down, for example, when he wanted a drink or the toilet. He also initially refused to eat and needed lots of encouragement even to help him to drink. In many ways he had regressed into an almost infant-like state, crying like a baby full of overwhelming emotions that could not be contained.

There were some initial thoughts on the causes of Elliot's presentation. His parents were in the process of separating as his father was leaving to be with another partner. This involved loss therefore not only of a relationship but also in the loss of the family home as it was going to have to be sold. Elliot's maternal grandfather had died a few months before which may also have provided a trigger. Elliot's mother had not yet expressed any sadness or pain, feeling that if she kept it all inside, she would be able to keep her children together. It was not until a long time into the admission that she let herself cry and, even then, she was more concerned about the well-being of her children than of herself. Elliot's father clearly felt guilty about what was happening and felt that he was to blame for Elliot's state but was reluctant to confront it. Thus, when the family were first admitted, it was very difficult for any member of the family to talk about what was happening and no one seemed able to find their voice.

As part of the unit's programme, all children can participate in the weekly music therapy group. In the first week of his admission, Elliot attended the group. He arrived late as it took such a long time for him to get himself from place to place. He sat in his chair sobbing with his body curled up in a foetal position. As the group progressed I noticed that Elliot was watching what was going on. He peered out from under his cloth to look at the different instruments that his peers were playing, although he never fully revealed his face. He even held and played some instruments. He was clearly interested in music and for brief moments the crying subsided. So, despite the huge physical and communicative restraints he had placed on himself, he was nevertheless able to let himself hold and play the instruments.

I'd like to now show a video extract of the second group that Elliot attended. We are all playing a game called "copy cat" as requested by one of the children. One person plays a motif on a metallophone which the other, the "copy cat," must repeat. The pair then swap positions. At the start of the extract you will see Elliot crawl to the other side of the instrument whilst sobbing intensely. He clearly wants to be in the right position even though it is difficult for him to move himself there. He listens carefully to the notes being played by his peer and then plays quite normally. He continues to sob but there are times when he is quiet and he is clearly concentrating and engaged in the game. When the activity finishes, he lets out a huge wail, as if he had been holding it in.

This is really to show you how he was presenting at the beginning of his admission.

[VIDEO EXTRACT]

After this group I discussed my observations with our multidisciplinary team. We all felt that Elliot might benefit from some individual sessions to give him time and space to explore using music as way to communicate and possibly as a means of self-expression. As Elliot was unable to speak, I wanted to try and help him find other ways to communicate. Having seen how interested and motivated he was in the group, I also wondered whether the process of music-making could help him feel positive about an aspect of his life as clearly he was struggling to identify anything positive.

Elliot appeared keen to come to his individual session although it took him a long time to get to the room. A journey which usually takes children one minute, took Elliot forty-five. He quietly listened to me singing *Hello* and seemed comfortable to be in the situation. At one point I tapped out a rhythm on an ocean drum which he then copied. We began to have a ‘musical dialogue,’ taking it in turns to play. This simple exchange, with us listening and responding to each other, made me feel that music therapy might be a way in for Elliot. He needed an opportunity to work at his own pace, without any pressure to be or to do anything. I felt, above all, that he needed patience, sensitivity and space.

I’d like to now show a video extract of a group that Elliot attended a few weeks later, to show how he had started to really engage in music therapy and in the music-making process. All the children are sitting around a drum. A beater is passed around the circle whilst I play some “passing” music on the piano. When the music stops, whoever is holding the beater can have a turn on the drum. I usually use this simple activity in a diagnostic way, observing how children cope, for example, with turn-taking, sharing, following and leading. I find it useful as a way to understand how children respond in different roles, how they use the control they have when it is their turn. In this case I was interested in how Elliot used his turn. Would he be able to play with me in front of the group? (he had not yet played completely on his own). How would the rest of the group respond?

When the extract starts, you’ll hear the end of another child’s turn before Elliot plays. Towards the end of his solo, I really felt that he was testing me to see whether I was following and listening to him. He slows down and then speeds up, which I follow. This felt like an important moment, as though through the music, I was gaining Elliot’s trust that I would accept him at his own pace, both literally and emotionally and not try to impose anything on him.

[VIDEO EXTRACT]

In his individual session the following week (it was now a month into the admission) Elliot wrote down that he would like us to play the theme tune of the film *Titanic*, a piece that we had played in the group session. He chose the drums and I, the piano. I was struck by how spontaneous his playing was, despite the fact that he was so physically restricted. He sat in the chair completely hunched over with his head resting on his knees which were bent and pulled tightly to his body. It seemed that while he was playing he let a part of himself relax and experience something beyond the regressive state that he was in. During these moments Elliot was creating something *with* someone else, we were equals both contributing to something creative. This felt significant as most of the time he seemed on his own, displaying his distress, the focus of worried attention.

The fact that Elliot showed motivation in his sessions and was able to suggest his own ideas was also important as he had not shown much motivation elsewhere on the unit. It was also noticeable that he managed to get himself to the music room quicker than to other places. During weekly team meetings I sometimes seemed to be the only person saying that Elliot was able to express his ideas and intentions beyond his basic needs and had been able to make choices. In some ways it seemed that throughout that time the sessions or the music held the healthy part of Elliot; the 8 year old boy rather than the infant, the part that could communicate and play in a way that was appropriate for his age. I was also able to feed back these points to Elliot's parents which was encouraging and sometimes a great relief for them, especially for his mother. So much of the time she was told about all the things that he was *not* doing whereas I was able to tell her what that he was making some progress. On one occasion he wrote down that he wanted his mum to come into his session to hear us playing *Titanic* together. This was a positive experience for them both as Elliot was able to let his mother observe him enjoying himself and doing something well. It also helped her to see that Elliot had not lost all his skills and was even developing new ones.

During musical improvisations Elliot's playing could be intense and his facial expressions and body language indicated that he was very engaged in the music. He also seemed aware of my musical presence, for example, by turning his head towards me if I reflected his musical ideas in my playing. Gradually his playing became more musically sophisticated and it became clear that music might become Elliot's area of expertise; something that he could succeed in and feel confident about. Through improvising and playing pre-composed songs with me, he could in

a sense be supported and held but also have the space to try out different ways of playing. He could “risk” ideas within the safety of the structures that I introduced at times. Perhaps it felt less threatening to communicate in this non-verbal situation than in other situations.

Sometimes Elliot played a very active role in the sessions, choosing many different instruments for us both to play, writing down his stylistic preferences. At other times he played a more passive role and requested to listen to some music that I played. Sometimes we sat in a comfortable silence. During one session I suggested that we play some reed horns. I wondered whether this might help Elliot to experience another way of using his voice, other than for expressing pain. He enjoyed playing these and the next week he chose the kazoos. To play a kazoo an actual sound must be made into the instrument. Elliot was able to do this and we had a communicative dialogue, taking it in turns to play. Bearing in mind that he had still not spoken in three months, the fact that he was using his voice for something other than sobbing was really significant. During the team meeting that week we all felt that this was an encouraging sign.

In the last session before the summer break, Elliot wanted to play many of the instruments and pieces that had come to characterise the sessions. It seemed that he was bringing together these things as a way of preparing for the break. During the good-bye song he tapped out a rhythm on a drum, later writing that he was saying “Good-bye Emma, have a good summer.” I remember feeling quite moved by this as it was thoughtful and demonstrated a good level of social skills. It also felt that he was, in a way, making the break ok for me.

Elliot continued to make progress and, when I returned to the unit, it was to find Elliot walking (albeit with an unusual gait) and talking. The family, in particular his father, had begun to engage much more actively in family therapy sessions and they were actually beginning to address some difficult issues. Elliot still kept part of his face covered with a flannel, sometimes chewing on a corner of it but it was possible now to see his eyes clearly. He was clearly not ready yet to part from the cloth and although he was making good progress, he still had difficulties expressing himself, communicating with others and was also finding it difficult to concentrate, especially in group situations. He did not talk about what had happened but it was clear that he remembered his time on the unit before the summer. In our first individual session back, he talked positively about our sessions and the music we had played. There seemed to be a real sense of trust between us and he was very keen to continue with his sessions.

I'd like to play you a brief video extract of a session from around this time. We are both playing kazoos, which had become a favourite of Elliot's. Our communicative exchange becomes very playful and humorous, which was a side of him I had not really seen until then. He brings in parts or motifs of pieces that we created together, so there's a sense of mutual understanding within the music.

You'll see that he still has a piece of cloth.

[VIDEO EXTRACT]

As Elliot was now communicating verbally I needed to rethink what music therapy could offer him. During the summer he had become really interested in pop and rap music and had began listening to different cds. He had shown a real interest in playing the guitar before the summer break and I wondered whether working further on this and possibly writing a song would be something that he would respond to. He appeared very keen to write a song and it was this that became the focus of our sessions until the end of his admission.

Each week we spent a part of the session working on Elliot's song. We talked about what he would like to write about, the style of music and what he wanted me to play. He tried out different ideas, different words and different ways that I could accompany him. The song therefore became an external part of Elliot that he could take away and think about, something that he felt positive and confident about. He could work on it independently but we were also able to work on the song together. He asked to play the song to staff and peers on the unit and practised at home with his family. Thus it acted as an interface between him and others when he was not quite ready to interact directly. I think that the process of writing the song coincided with the process of his preparation for leaving the unit. About a month before his discharge, when we were working on his song, I asked Elliot how he felt about singing without his flannel. I had never remarked on it before but I felt that enough trust and understanding had developed between us to enable me to do so at this point. He cautiously placed the flannel on the top of his guitar and sang. Immediately after he replaced it over his mouth again. This was the first time he had been totally without the cloth for over five months. I found it interesting that he felt he could sing without covering his mouth but not talk. Perhaps it felt safer and less exposing. I began to wonder whether the flannel symbolised the fact that he had not

been able to speak all those months and had acted as a mask to hide his feelings. Elliot clearly needed the flannel and was still not quite ready to let go of it.

In preparation for our last session Elliot asked whether we could video his song so that he could have it to keep. He also asked whether we could video it twice as he wanted me to have a copy. He talked about wanting to play it to his family and friends afterwards. When he arrived for his last session, he came into the room, threw his flannel on the floor by the piano, and that is where it stayed for the rest of the session. At the time it felt that he wanted to leave this final link with whatever had caused his illness in the music room, with me.

I am now going to play you Elliot's song.

[VIDEO EXTRACT]

After the session I felt overcome with emotion and cried intensely for some time. I had kept myself together all those months so that I could be available to contain some of Elliot's feelings but now I needed to gain a sense of release. My crying felt incredibly cathartic and afterwards I wondered whether I was expressing some of the tears that the flannel had suppressed. I thought about Elliot's mother and how it taken her such a long time to cry. What I was feeling was only a part of what she and her family must have gone through.

After Elliot had left the unit there was a discharge meeting for all the professionals who had been involved in his care. During the meeting, his mother told us that she had heard Elliot singing in his bedroom at home about his experiences and feelings about his admission. I felt that I had helped him find a way to use music as a way of expressing himself which he can continue to use in the future, either on his own or with others. Perhaps this was one of the most important and useful things that music therapy had been able to offer him.

Elliot had clearly suffered some kind of trauma which had manifested itself in severe psychosomatic symptoms. The cloth and the hiding of his face played an important part in this as it was not until the very end that he was able to separate himself from it. As I discussed earlier, even though the family were going through a very painful process, it was talked about very little. Elliot's mother took a long time to talk about how she felt and when she finally did, it was to admit that she was lit-

erally “doubled up in pain” about the separation with her husband. However, she felt that her role as good mother and professional nurse did not enable her to express this pain. In many ways it seemed that Elliot had taken on his mother’s pain and the ensuing symptoms in order to protect her from feeling them. As he was initially the only person in the family to express grief, perhaps he perceived his role in the family to take on their pain. While it was not my role to try to help him talk about what had happened, it was important to keep in mind the impact that these events may have had on Elliot. Elliot was offered many opportunities to talk, for example with the unit’s psychologist and family therapist about these difficulties. Therefore I felt that music therapy sessions should provide a space for him to come each week *without* pressure to talk and help him to explore other ways of expressing himself.

I still find it moving and fascinating that in this case, music was able to reach someone in great emotional and physical distress and play a part in his gradual recovery. It seems that even when many of the body’s functions are damaged, there is always the ability to respond to music. In Elliot’s case, even though he was unable to do so many things, he was still able to play and listen to music and use it as a way to communicate, express himself and interact with others. The sessions also enabled him to experience something away from the family and achieve a sense of independence. The sessions worked around what he brought to the room and gave him space and time to be in. My approach had to be flexible, open-minded and sensitive in order for him to find his way and yet I also had to let my own personality respond so that a genuine trusting relationship could develop.

The process of writing this paper has been an experience in itself. It has taken me a long time to actually put this case together. To an extent I think I was reluctant to make an ending and finally separate from it, rather like the way Elliot was reluctant to part with his cloth. Only right at the end was he able to disregard it when he felt that he could leave it with someone, perhaps someone that he felt understood. Maybe that is what I am doing with you today.

Elliot’s last words to me were “Thank you for the music.”

CHAPTER 11

Music therapy and cognitive rehabilitation with schizophrenia: a controlled study

Ceccato, Enrico; Caneva, Paolo & Lamonaca, Dario

Abstract

It has been widely proved that cognitive disfunctions are a primary characteristic of the schizophrenia and, for some authors, they have assumed the meaning of the central and primitive characteristic of the trouble (Harvey, 1997).

Major alterations concern the attention, the memory and the executive functions (Rund, 1999).

The rehabilitative treatment that is used has been started from numerous researches, these show the association between the impairment of the cognitive functions and both a worse functional outcome (Green, 1996; Silverstein et al., 1998; Green et al., 2000) and a worse psychosocial functioning (Addington et al., 2000; Liddle, 2000; Bell et al., 2001;), in patients with diagnosis of schizophrenia.

The aim of this study was to appraise the possible effects of a particular type of music therapeutic protocol, called S.T.A.M. (Sound Training for Attention and

Memory) created by our group, on specific components of attention and memory in schizophrenic patients.

The research was carried on with an experimental approach working on groups. Neuropsychological tests have been used in order to appraise the efficacy of the training, showing statistically significant variations. The results of the study will be discussed.

Introduction

Cognitive deficits in schizophrenic pathology have been studied for a long time; even Janet and Krepelin noticed a reduction in mental efficiency in these patients a long time ago (Ey et al., 1995).

However, in the study of eziopathogenetic and clinical-therapeutic aspects of schizophrenic pathology, cognitive disfunctions have only been given secondary importance.

Cognitive alterations in fact have been seen as secondary aspects for a long time, especially in relation to the effects of institutionalization or motivational reduction in schizophrenic patients. On the contrary, it is now certain that cognitive disfunctions are a primary characteristic of pathology and it is considered by some authors the central and primitive characteristic of the disorder (Harvey, 1997).

It seems to have been proved that such deficiencies are independent from the psychopathological phenomena: transversal and longitudinal studies demonstrate that different alterations persist during the entire course of the disease, quite apart from the remission phase and exacerbation of clinical symptoms during the course of the disorder (ibid., Aleman et al., 1999).

It also seems that subjects developing schizophrenia, show early on cognitive deficiency signs, (some difficulty with reading and solving mathematical tests) signs however, that are not so serious until the first episode of the disorder appears, with a pronounced decline of cognitive performances. In most patients, these deficient performances persist without worsening, until old age (senility) (Hoff et al., 1999).

Cognitive disfunctions, connected to schizophrenia, involve many aspects of mental activity.

However, the main alterations appear in attention, in memory and in executive functions (Rund et al., 1999; Tamlyn, 1992): attention in its components like vigilance, sustained attention, selective attention and visual discrimination; the memory in its components such as short-term memory and verbal recall; executive functions such as ability to plan, organize and accomplish actions, such as modulating activity levels, integrating behaviour, self-monitoring and recognizing mistakes.

The issue of pathology depends very much on deficiencies in the above-mentioned functions, which means that the presence of such dysfunctions seems to predict, over the long run, not positive outcomes (Green, 1999).

The seriousness of these deficiencies may vary from subject to subject but in general, the level of damage to each function varies as in the following prospectus:

TABLE 1. Seriousness of damage to cognitive functions in schizophrenic patients

| SERIOUSNESS OF DAMAGE TO COGNITIVE FUNCTIONS IN SCHIZOPHRENIC PATIENTS | | |
|--|----------------------------------|---------------------|
| LOW | MEDIUM | HIGH |
| Perceptual capacity | Distractability | Executive Functions |
| Long-term memory | Visual and motor capacity | Series learning |
| Word's comparison | Spaciousness of sensorial memory | Vigilance |
| | Working memory | Verbal fluency |
| Seriousness of damage is pointed out from number of standard deviations (SD) under the media of normal subjects. Low = 0,5 Sandard Deviation; Medium = 1-2 SD; High = 2-5 SD. Translated from Italian, Harvey, 1997. | | |

Aim

Several research studies indicate that in patients diagnosed as schizophrenic, compromised cognitive functions are associated to a negative functional outcome (Green, 1996; Silverstein et al., 1998; Green et al., 2000) and that there is a considerable correlation between cognitive deficiencies and social behaviour (Addington et al., 1998; Addington et al., 2000; Liddle, 2000; Bell et al., 2001).

Given that cognitive alterations in schizophrenia don't usually degenerate during the pathological development (Rund, 1998), the aim of our study was to evaluate possible effects of a particular music therapy protocol, the S.T.A.M. (Sound Training for Attention and Memory), developed by Enrico Ceccato and Paolo Caneva, on specific components of attention and memory.

The focus on attention regards "selective attention" meaning in this case, the ability to select internal or external sources of stimulation in the presence of information and hence the capability to concentrate one's attention on what is interesting and to elaborate in a privileged way the important information for the pursued aim (Stabulum, 2002); the "sustained attention" that is the ability to keep attention on an event for a prolonged time; the "alternate attention" is the mental flexibility to move from one task to another. Regarding memory, we studied "short-term memory", meaning working memory in charge of handling as well as retaining information (Baddeley, 1992).

We also assessed how the possible improvement in these functions can be extended to the daily life of patients, in particular, their social behaviour. For this reason we used an evaluation instrument of social disability in schizophrenic patients, the L.S.P. (Life Skills Profile) (Rosen et al. 1989).

The use of music seems to be a special way to obtain good results in therapeutic setting; on one hand it is a means with which one can activate and stimulate several functions regarding cognition and motion, but on the other hand, it can be suggested and used for the aspect of play and pleasure that can help the realization of rehabilitation programs (Tang et al., 1994; Pavlicevic et al. 1994; Verucci et al., 1998; Glickson et al. 2000, Hayashi et al, 2002).

It is extremely important to understand what is meant by music therapy, what is actually done during the sessions, if any results are obtained and through what processes. With regards to this, S.T.A.M. is a protocol consisting of a progressive series of sound/musical proposals created and then recorded on a CD which

becomes the instrument used in a sequence of step-by-step exercises aimed at stimulating and checking attention and memory.

We would like to underline that regarding attention, this protocol is based on a hierarchical model suggested by Posner and Rafal (1987), and regarding memory it is based on the working memory model suggested by Baddeley (1992).

The experiment is part of a program that wants to give music therapy more “objective data” on which to base its ideas. The aspiration is certainly not to do this in an exhaustive way but rather to follow research and experimentation, no matter what type it is, in a field which has reached a certain level of maturity but lacks research studies which try to evaluate results and efficiency of those studies in a less subjective and anecdotal way (Ricci Bitti, 2001).

Besides several descriptions and analysis of clinical cases, very useful suggested by the authors according to their theoretical orientation, we believe and hope that, as time goes by, the sessions aiming at an experimental verification of the results will increase considerably because there is a growing need for clinical verification and scientific comparison. Keeping this in mind, our research is a pilot study to verify the rehabilitation capacity of the aforementioned protocol.

Subjects

The subjects were all people who suffering of schizophrenic Disorder, the diagnosis have been done using the DSM IV (APA, 1994).

They were all volunteers who were attending the day program at the “Daycentre Tulipano” in Legnago (Hospital of Legnago, Verona, Italy). The participants were divided, not randomly, to form two homogeneous groups of equal numbers (8 in both groups) and so that in both groups there were subjects with similar clinical history. They were selected on the basis of their cognitive deficits, age, sex, and education. On the contrary, we did not take into consideration social variables such as the family situation and marital status. Two subjects of the control group left the experiment before the end because one found a job after three weeks from the beginning of the research and the other was admitted to hospital for a relapse of his positive symptoms.

Method

Research was carried out using the experimental form using groups. The sixteen patients attending the Tulip Centre were divided into two groups of eight people: one group was experimental and participated in the specially designed experiment using the S.T.A.M. method, and the other group was a control group and participated in improvisational music therapy sessions. During the experiment we used equivalence criteria to reduce as much as possible non-specific factors of change. For both groups we had sixteen weekly meetings and each session lasted fifty-five minutes. For both groups the experiment was conducted in the same room, first one group would go first and then the other group would go first, always with the same music therapist. For both groups we had the participation of the psychologist who devised the S.T.A.M. method and two day-care centre workers. Before and after the experiment we used W.M.S. (Wechsler Memory Scale) and PASAT (Paced Auditory Serial Addition Test) to evaluate the participants neuropsychologically and L.S.P. (Life Skills Profile) to evaluate their social disability.

The entrance tests were given a week before the beginning of the experiment and the exit tests were given a week after the end of the experiment. Both entrance and exit tests were given at the same hour, in the same room, and in the same order. The subjects were tested separately one at a time.

Materials

ATTENTION EVALUATION

Paced Auditory Serial Addition Test (PASAT; Gronwall, 1977).

This is a test which evaluates the verbal-auditory attention but also selective and prolonged attention are involved in performing a task.

The test consists of a series of 61 figures that the examiner must read at a different pace from a figure every 1 or 2 seconds to one every 2 or 4 seconds.

It is presented as a recorded message.

Patients must add 60 pairs of random figures so that every figure is added to the previous one. For example, if the examiner reads the numbers “2,8,6,1,9” when the

examiner says 8, the correct answer is “10,14,7,10”. The performance is evaluated according to the percentage of correct answers or on the average score.

MEMORY EVALUATION

Wechsler Memory Scale (W.M.S.) (Wechsler, 1997).

There are two parallel forms of this scale, form 1 and form 2. This series of memory evaluation tests consists of 7 sub-tests:

1. information: the subject is questioned about his age, birth date, the name of the president of Italy, the name of the previous president, the name of the Pope, and the name of the mayor of his city.
2. orientation: the subject is asked five questions about the year, month, age, place, and city where he lives.
3. mental check: the subject has to count backwards from number 20-1, repeat the letters of the alphabet, count by three.
4. logical memory: immediate repetition of two short stories.
5. repetition of numbers: digital span backwards and forwards.
6. visual reproduction: immediate reproduction of geometrical drawings.
7. association: ten associations of pair words are recounted: immediately after the examiner reads the first word of each pair, the subject must remember the second word of each pair.

There are 3 presentations and 3 repetitions of the pairs. The total score (the sum of the score obtained for each subtest) gives a correct score to better evaluate memory (M.Q. uses a corrective coefficient to take into consideration the age of the subject).

SOCIAL DISABILITY EVALUATION

Life Skills Profile (L.S.P.) (Rosen et al., 1989).

This profile was set up specifically to evaluate global functioning and social disability in schizophrenic patients. It evaluates 5 areas of functioning:

Self-care, calmness, social contact, communication, responsibility.

The total score gives an overview idea of social behaviour.

These three tests are validated for the Italian language.

Research Protocol

RESEARCH PROTOCOL FOR THE EXPERIMENTAL GROUP

The S.T.A.M. protocol is divided into 4 phases, one for each specific function (see aim above). Each phase of S.T.A.M. is organised into exercises which go from the simplest to the most difficult, both for groups and individuals. This is only an introduction above this method. We are preparing a specific paper to elicitate in what it consists.

Phase 1: assosiation stimulus-movement. Music therapist instructs subjects to link particular sound stimuli with specific body movements. Participants freely walk in the room listening to recorded music. When one sound stimulus appear over recorded music, the music stops for a while and the movement connected to the stimulus is performed; when the music starts again the subjects starts walking again.

Phase 2: reaction to acoustic stimuli. The task consists of reacting to previously heard acoustic stimuli. The sound stimuli of the previous exercise are used. Reacting means recognizing the type of stimulus, counting how many times it is present in a recording with noises in the background.

Phase 3: shifting attention (1). The task consists of reacting to a target stimulus, a drum, by clapping one's hands after having heard it, but not clapping when the drum is preceded by a second target stimulus, a cymbal. When the therapist gives a signal, one must react by clapping one's hands only when the drum is preceded by the cymbal. The task is then made more difficult but the therapist giving this signal more frequently.

Phase 3: shifting attention (2). Participants listen to a rhythmic sequence, which is a regular, alternating sequence of bass drum and snare drum. The task is to follow the bass drum beat and snare drum beat by alternately clapping hands and tapping the floor with one's foot.

Phase 4: orderly and inverted repetition. The task consists of listening, recognizing and repeating in an orderly or inverted way sequences of previously recorded sounds. The stimuli have been previously sampled from instruments selected for the exercise. The exercise will go from various simple repetitions, for example three sounds, to more and more difficult ones.

PROTOCOL OF INTERVENTION FOR CONTROL GROUP

The characteristics of the activities suggested for this group are based on the improvisational models of music therapy that could be go back to the creative model of music therapy proposed by Nordoff and Robbins (Nordoff & Robbins, 1977).

It is not accidental that many aspects of this model are very different from the S.T.A.M. protocol infact, first of all, there is not a series of exercises so strictly structured and progressive. The experience is lived in the “here and now” of the session.

The activities can be reduced to exploration, improvisation, composition and execution of musical sound material. The instruments are the voice, the body and the instruments suggested by the music therapist. The general aim is to give successful positive experiences, to express emotions in different ways, not only verbally, to express one’s musical ability. The characteristic of the control group is in the way of conducting it, mainly supportive and consultative, more than a precise proposal.

Results

TABLE 2. Tests results

| Average of test’s results | | | | | | | |
|---------------------------|------|---------|-------|-------|---------|-------|-------|
| Group | Age | Pasat 1 | WMS 1 | LSP 1 | Pasat 2 | WMS 2 | LSP 2 |
| experimental | 34,6 | 93.5 | 92.25 | 138.7 | 76.8 | 101.6 | 144 |
| control | 40,5 | 128.83 | 89.5 | 127.3 | 114.3 | 91.5 | 133.1 |

TABLE 3. Tests results 2

| | Group | N | Differences between averages | Std. Deviation |
|--|-------|---|------------------------------|----------------|
|--|-------|---|------------------------------|----------------|

TABLE 3. Tests results 2

| | | | | |
|-------------|--------------|---|-------|--------|
| t1-t2 pasat | experimental | 8 | 16,63 | 39,359 |
| | control | 6 | 14,50 | 28,690 |
| t2-t1 wms | experimental | 8 | 9,38 | 7,386 |
| | control | 6 | 2,00 | 4,336 |
| t2-t1 lsp | experimental | 8 | 5,25 | 4,496 |

STATISTICAL ANALYSIS

The obtained results were processed with Wilcoxon test for two independent samples. The level of statistical significance was defined in all cases as 5% ($P < .05$).

TABLE 4. Results using the Wilcoxon test

| Results: Wilcoxon test | | | | |
|--|---|---|----------|----------------|
| CONTROL GROUP | | | | |
| Comparison between pasat 1 and pasat 2 | | | | |
| | N | T | Z | p-level |
| PASAT 1 & PASAT 2 | 6 | 4 | 1,36277 | .172964 |
| | | | | |
| Comparison between wms 1 and wms 2 | | | | |
| | N | T | Z | p-level |
| WMS 1 & WMS 2 | 6 | 3 | 1,21356 | .224925 |
| | | | | |
| Comparison between lsp 1 and lsp 2 | | | | |
| | N | T | Z | p-level |
| LSP 1 & LSP 2 | 6 | 1 | 1,991741 | .046408 |

TABLE 4. Results using the Wilcoxon test

| | | | | |
|---|---|---|----------|----------------|
| | | | | |
| EXPERIMENTAL GROUP | | | | |
| Comparison between pasat 1 and pasat 2 | | | | |
| | N | T | Z | p-level |
| PASAT 1 & PASAT 2 | 8 | 8 | 1,40028 | .161439 |
| | | | | |
| Comparison between wms 1 and wms 2 | | | | |
| | N | T | Z | p-level |
| WMS 1 & WMS 2 | 8 | 1 | 2,380476 | .017296 |
| | | | | |
| Comparison between lsp 1 and lsp 2 | | | | |
| | N | T | Z | p-level |
| LSP_1 & LSP_2 | 8 | 0 | 2,366432 | .017966 |

The subjects who participated in the music therapy experimental activity significantly improved their performances to W.M.S. ($p = .017296$) and to L.S.P. ($p = .017966$). Control group improved his score only in L.S.P. and with a low significant level ($p = .046408$).

We did not note any other significant changes as regards to the other tests used.

Discussion

Obviously, this is a pilot study and the small number of people involved does not permit one to generalize the obtained results. However, the study can be seen as an excellent starting point to implement the use of the S.T.A.M. protocol in the rehabilitation of attention and memory in schizophrenic patients.

The data from the statistical analysis show a significant variation with regards to memory performances tested with W.M.S. (Wechsler Memory Scale). But that does not rule out the possibility that there can be further relevant and significant findings from other tests using more subjects.

Besides the fact that the test results were statistically significant, it was also noted that there were positive changes in the subjects from the experimental group in comparison to the control group.

The suggested protocol proved to be usable even if there were initial fears about the chances of drop-out due to the structured nature of the protocol. It must be underlined that a good relationship with the patient is fundamental to the success of the experiment.

Some consideration must be given to changing and improving the protocol to see if the results can be applied to daily life.

Having obtained a statically significant difference for L.S.P. (Life Skills Profile) in both groups leads us to believe that the two activities could improve global functioning and social ability in schizophrenic patients but with a relevant better result for the experimental group. This seems to demonstrate our initial hypothesis and underlines the importance of cognitive rehabilitation with schizophrenic patients. We need more data to say that the S.T.A.M. could be a good protocol to obtain results in this way.

Other considerations are more into the development of exercises on which we will have to intervene to define more objectively how and when to go from one activity to another.

In our case, before starting the experiment we decided to dedicate four meetings to each phase regardless to how the exercises were done and their variations made by the components of the group.

As discussed in the introduction, we underline the need to start thinking about music therapy in terms of Evidence Based Music Therapy (Vink & al., 2002; Edwards, 2002) we are aware of the difficulties of these but at the same time we are sure it is possible and by now it is almost a necessity.

We hope that this research will contribute to stimulate discussion on it.

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CHAPTER 12

The Tone-Transfer-Therapy“ as a Vibro-acoustic Method

Cramer, Annette

Abstract

In the Tone-Transfer-Therapy® we work with a very special tone – the basic tone of the individual human voice. The basic voice-tone is a characteristic parameter of the individual and indicates the relaxed state of the so-called “chewing-voice”. This tone is as a rule about three tones under the speaking fundamental frequency (the intonation, in which we can speak a long time without getting strenuous). The basic voice-tone can be tuned on a vibroacoustic instrument and afterwards transferred in the human body.

For handling the Tone-Transfer-Therapy® in the best way possible there was developed the therapeutic “Tone-Transfer-Monochord”, which was rewarded as “*especially remarkable and innovative for the musictherapeutic practice*” on the International Congress for Music Therapy 1996. With this instrument the vibrations can be transferred through a very thin and flexible swinging panel, which can be adapted to the human body.

The Tone-Transfer-Therapy® can be used in all three sections of music therapy:

1. in the orthopaedagogic music therapy
2. in the music medicine
3. in the psychotherapeutic music therapy.

Experiences throughout 10 years practice in ambulanced and clinical work show that the Tone-Transfer-Therapy® can

- be helpful for vocal and auditive problems
- lead in deep relaxation
- help to support physical and psychic self awareness
- help to release pain
- support during life-crises-problems

The vibratory sense

All instruments transfer their vibrations through the air. They are perceived not only through the auditive sense, but also through the vibratory sense.

We have to differ between the extero-receptive senses which receive external stimuli like hearing and touching, and the interior receptive senses which receive inner stimuli, like, for instance, tension or pressure. Between them we have as an intervention system 1) the equilibrium sense with its receptors of the inner ear and the complicated connections to eye movement and to posture, and 2) the vibratory sense, which receives inner vibrations as well as external vibrations (Atwood/MacKay 1994).

The perception of vibration is called pallesthesia. Responsible for the vibratory sense are specific mechanoreceptors. The slowly adapting receptors (SA) seem to be responsible for sensations of the tactile magnitude or pressure, and because of their high sensitivity to velocity, they probably also contribute to transient and vibratory sensibility. We have two main types: the Merkel disks (type I) in the basal epidermis and the Ruffini endings (type II) embedded in connective tissue, responsive to lateral stretch and even to direction of skin stretch; beyond that they might provide information about the weight of objects.

FIGURE 1. The fundamental properties of touch sensation

Touch sensation: Fundamental properties

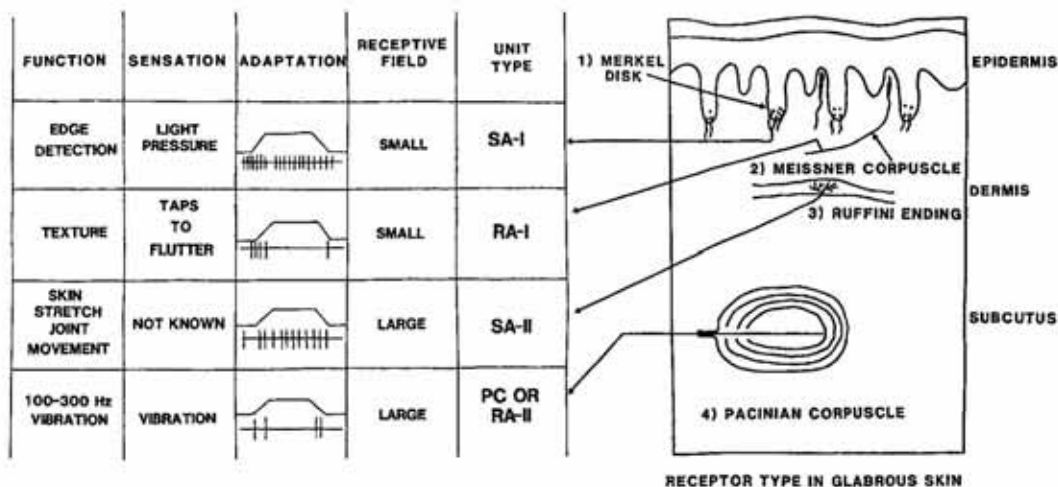
- Different qualities or 'submodalities' of touch are mediated by different types of primary sensory receptor cells
 - temperature; Merkel's discs
 - pressure; Ruffini corpuscles
 - vibration, texture; Pacinian corpuscles
- Each receptor type is specialized for responding to different types of stimuli
 - some have rapid adapting response, others are slowly adapting

Then we have the rapidly adapting afferents type I (RA-I), they innervate the Meissner corpuscles, which are located in dermal papillae protruding into the epidermis. They can provide shape and intensity information during active touch. They are especially important in discriminations of textures moved across the skin.

The rapidly adapting afferences type II (RA-II) end in the Pacinian corpuscles. For vibratory therapies they are the most important mechanoreceptors. They act as a mechanical filter, they relay high frequency and attenuate low-frequency components of skin compression to the axon terminal. Pacinian corpuscles are extremely sensitive to transient indentations of the skin over large areas such as a complete digit and part of the palm. They can already be activated by gently blowing on the skin and they respond to vibrations. The responses of Pacinian afferents follow a

cycle of a sinusoidal vibratory stimulus. However, unlike Merkel corpuscles which respond with lowest threshold in the 30-40 Hz range, Pacinian corpuscles can detect high frequency vibration less than 1 μm in amplitude and at frequencies up to 1500 Hz (Iggo 1999).

FIGURE 2. Receptor types and characteristics of afferent fibers from the glabrous skin of the human hand. RA=rapidly adapting; SA=slowly adapting; PC=Pacinian afferent. The ramp in the adaptation column indicates skin indentation. From Kaas, J. H. (1990). Somatosensory System. In G. Paxinos (Ed.). The Human Nervous System (p. 815). San Diego: Academic Press



They might be the only mechanoreceptors which are able to sub serve the sensation of high frequency vibration. Therefore their major rule seem to be in detecting and roughly locating sudden skin deformations produced by ground and air vibrations and by skin contacts.

Pacinian corpuscles are located in the lower skin of the palm, in the sole of the foot and can also be found in many places outside of the skin: at the ligaments, tendons, muscles, skin bone, tendon capsules, in the external genitalia, mammary glands, even in the intestines, in the tissue around the bladder and in the pancreas. The vibratory sense is therefore in connection with the entire body via several receptor organs. As Katz (1925) and Knudsen (1928) found out, this sense is the phyllogenic ancestor of the auditory sense.

Hence we get access to the world of sound through the vibratory sense and through the auditory sense. Vibratory perceptions are – according to Kampik (1930, 21) – *“so close related to auditory perception that they are often mixed up.”*

This close relationship between auditory and vibratory sense presents itself especially in their mode of stimulus. In both cases the stimulus is the same: both senses react to mechanical stimuli, both reply to vibrations of the air, of elastic or other appropriate material. When sound waves of a certain frequency have enough intensity, the mechanoreceptors of the basilar membrane in the cochlea and the mechanoreceptors of the skin (Meissner and Pacini corpuscles) react and change the mechanical stimuli into appropriate nerves activities, whereby the vibratory sense reacts particularly well to sound vibrations in a frequency range between 16 Hz and 1300 Hz (Keidel 1984).

We have to differ between three possibilities of a sound transmission via the vibratory sense: aero-cutaneous, cutaneous-cutaneous and mechano-cutaneous.

- Aero-cutaneous: sound waves are transmitted by air. A process well known to concert-goers, as far as he/she opens all senses for the music. When the loudspeaker amplifies the sound waves in a manner that they can be perceived “free within the room”, in complete isolation of resonating objects, we do also have an aero-cutaneous sound transmission.
- Cutaneous-cutaneous: sound waves are transmitted from skin to skin, for instance if hands are placed directly on the chest, neck, throat or on top of the head of a speaker or singer. On specific parts of the body surface it is possible to feel vibrations of voice sounds, therefore deaf persons can notice vibro-tactile sounds of words and can learn to discriminate the different characteristics of sound speech production. Of course these vibrations can be felt on one’s own body: a possibility to get in touch with one’s own voice.
- Mechano-cutaneous: sound waves are transmitted by contact with vibrating material, as for instance contact with an instrument, a loudspeaker, or the vibrating floor. Ever since Van Uden has pointed out in 1955 the great significance of the vibratory sense for hearing education, the mechano-cutaneous sound transmission plays an important role in the education for the deaf or near-deaf.

The VibroAcoustic Therapy (VAT) and VibroAcoustic Music therapy (VAM)

VibroAcoustic therapies are mechano-cutaneous and sometimes aero-cutaneous as well. We differentiate between the VAT = “VibroAcoustic Therapy” and the VAM = “VibroAcoustic Music therapy”. Research and/or development of vibro acoustic use include applications to manage pain; reduce symptoms for patients in chemo-therapy; reduce stress; distract patients during biopsies, aspirations, and other procedures; increase range of motion (ROM) and muscle tone and in physical therapy or rehabilitative therapy following knee replacement; help prepare patients for surgery or those who are recovering; and provide sensory stimulation for people who are hearing impaired and developmentally disabled. Vibroacoustics can also increase quality of life and be used to manage behaviour in psychiatric settings, geriatric facilities, child life centres, and palliative care facilities (Skille 1991, Wigram 1996, Lehtikoinen 1997).

In VAT the vibrations are transferred in the human body by the direct contact to vibrating materials and sometimes simultaneous via loudspeakers through the air, sometimes connected with headphones. Vibroacoustic equipment was developed between 1970 and the late 1980s when one recognized the value of felt vibrations combined with the auditory effects of music or sound. The technology uses speakers or transducers placed within mats, mattresses, chairs, recliners, tables, or soft furniture to provide a physiologic and auditory experience.

In VAT the most systems apply selective low frequencies as pure tones or so called full frequency music (especially composed music, that maximizes vibration effects and qualities via specific low, pulsed sound pulsation, scanning, and directional sound movement).

TABLE 1. Differences between the VAT and the VAM

| | VibroAcoustic Therapy (VAT) | VibroAcoustic Music therapy (VAM) |
|--------------------------------|---|---|
| sound- transmission | mechano-cutaneous and <u>often</u> aero-cutaneous | mechano-cutaneous and <u>always</u> aero-cutaneous |
| vibrating material | speakers or transducers placed within mats, mattresses, chairs, recliners, tables, or soft furniture | music instruments |
| transfer of sound | sound is recorded | sound is always live |

TABLE 1. Differences between the VAT and the VAM

| | | |
|------------------|---|---|
| | selective low frequencies as pure tones or so called full frequency music, especially composed music, that maximizes vibration effects and qualities via specific low, pulsed sound pulsation, scanning, and directional sound movement | “therapeutic sounds” (e.g., D or G), accords or complex pieces of music |
| subject of sound | | |
| dialog | during the applications sometimes, but not necessary | always during the application |

The music therapy has its focus in the VAM , in which instruments transfer sounds and music. Since about 25 years the therapeutic instruments of the VAM are permanently developed. We have for example the “Verrophone” (from Bitterli and Reckert, Switzerland), the large “Kombi-Schlitztrommel” (from Böhme, Heuchelheim/ Germany), the “Klangstuhl” (from Deutz, Berlin) or the “Klangwiege” (from Harbek-Allton Klangkunst/Germany), “Klangschaukel”, “Klangwiege” and “Klangfreund” (from Vogt, Rimpar, Germany).

They all have in common that the therapist is in direct contact with the client while playing the instrument; hence the dialogue form principle of therapy can be guaranteed. The therapist can react to his client with his playing and has a binding with him by his hearing, because the instrument reflects what the client is hearing. This connection is enhanced by the visual sense: the observation of the client’s breathing, face colour and movements of fingers or feet.

THE TONE-TRANSFER-THERAPY®

The therapeutic monochord of the Tone-Transfer-Therapy (built by Jan Dosch/ Munich) is a very light-weight string instrument with 25 strings, all tuned on the same tone¹. With this instrument the vibrations are transferred through a thin flexible swinging panel, which is connected with the instrument by tuning sticks.

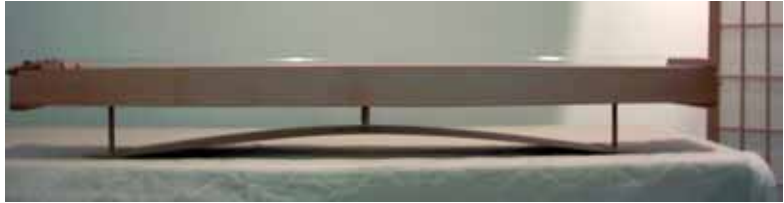
FIGURE 3. *The therapeutic monochord of the Tone-Transfer-Therapy® picked to pieces (Patent-Nr.P4431 904.5)*



So the vibrations are directly transferred from the top of the instrument to the panel. The tuning sticks have different sizes, therefore the instrument with its panel can be adjusted to various shapes of the human body.

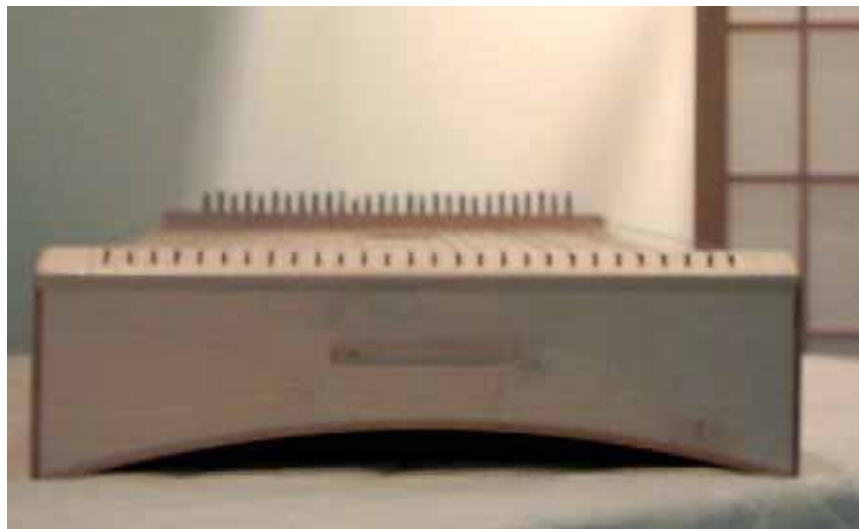
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1. In literature the monochord is frequently translated with “one-string”, since in ancient times the most frequent model of this instrument consisted of one string. But actually, the one-string instrument was during this time designated as “Χανων” (canon, rule, guideline; compare Euclid, Gaudentius, Ptolemaus, Pollux, and others). Instruments with several strings – in those days already in use, were called monochords. They were also used as musical instruments, however, not very successfully, because they were difficult to play. Today we find the monochord in the tjin, the Chinese curved zither; it might be possible that it is the origin of the multi-string monochord. Yet for both instruments – the one-string and the multi-string instrument – the term monochord has been accepted. To avoid misunderstandings Näf (2000) translates monochord with “one-string-instrument”, because even with multi-string instruments all strings possess the same tone value.

FIGURE 4. The therapeutic Monochord in different shapes



The therapeutic monochord comes in three sizes: The smallest one (measure: 60 cm long) is especially useful for the work with babies and small children and old bed-ridden people. Its small size permits application to specific parts of the body, for example a leg or arm, and of course at the foot soles, an effective method to force a patient out of his head and stand him on his feet. The medium-sized (measure: 90 cm) and the large instrument (measure: 120 cm) are to be placed on the stomach or back.

FIGURE 5. Two new models of the therapeutic monochord, left from Dosch/Munich, right from Deutz/Berlin



All three instruments differentiate themselves also by their basic tuning, which is dependent of the different length of strings. The smallest instrument is usually tuned to d', the medium-sized to d and the largest on D².

At this point I want to emphasize that all three instruments have “basic tuning”, that means whenever it becomes necessary the tuning can be changed quickly by a movable bridge. And that's the essential characteristic of the Tone-Transfer-Therapy: while all the vibro-acoustic music instruments offer so-called “therapeutic sounds” (e.g., D or G), accords or complex pieces of music, the therapeutic monochord is by contrast the only instrument that is to be “tuned” individually on the client. I get this individual tone by determination of the **basic voice-tone** (Eigenton) or the **speaking fundamental frequency** (Indifferenzlage) (Cramer 1998a).

TABLE 2. The differences between the instruments of the VAM and the therapeutic monochord of the Tone-Transfer-Therapy

| | Instruments of VAM | Therapeutic monochord of Tone-Transfer-Therapy |
|---------------------------|---|---|
| sort of instrument | mostly, but not always string-instruments | string-instrument |
| construction | mostly heavy, can not picked to pieces | very light, can completely picked to pieces and be transported |
| how to play | noises, "therapeutic" tones, sounds or complex music pieces | only individual tones that correspond to the clients |
| how to use | for almost everybody | for almost everybody |

The individual speaking fundamental frequency is the average pitch at which one speaks, therefore it is the most used frequency while speaking. It is usually the strongest acoustic energy in a person's voice. The fundamental frequency vibrates in the medium speaking level, which we find in the lower third of the individual vocal range. The speaking pitches change while speaking with a measure of deviation from a quart to an octave around the medium speaking level. Simultaneously the speech intensity varies in the dynamic accent (this is the medium quantity of voice intensity) from -5 to +5 dB.

If the speaker maintains on this specific frequency, he can speak for a prolonged time without getting tired. A significant raising and tensing of the vocal folds may

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2. Notes given in italics both capital and lower-case and whether with or without ticks, as C, g", have specific octave pitches according to the system which is nowadays prevalent.

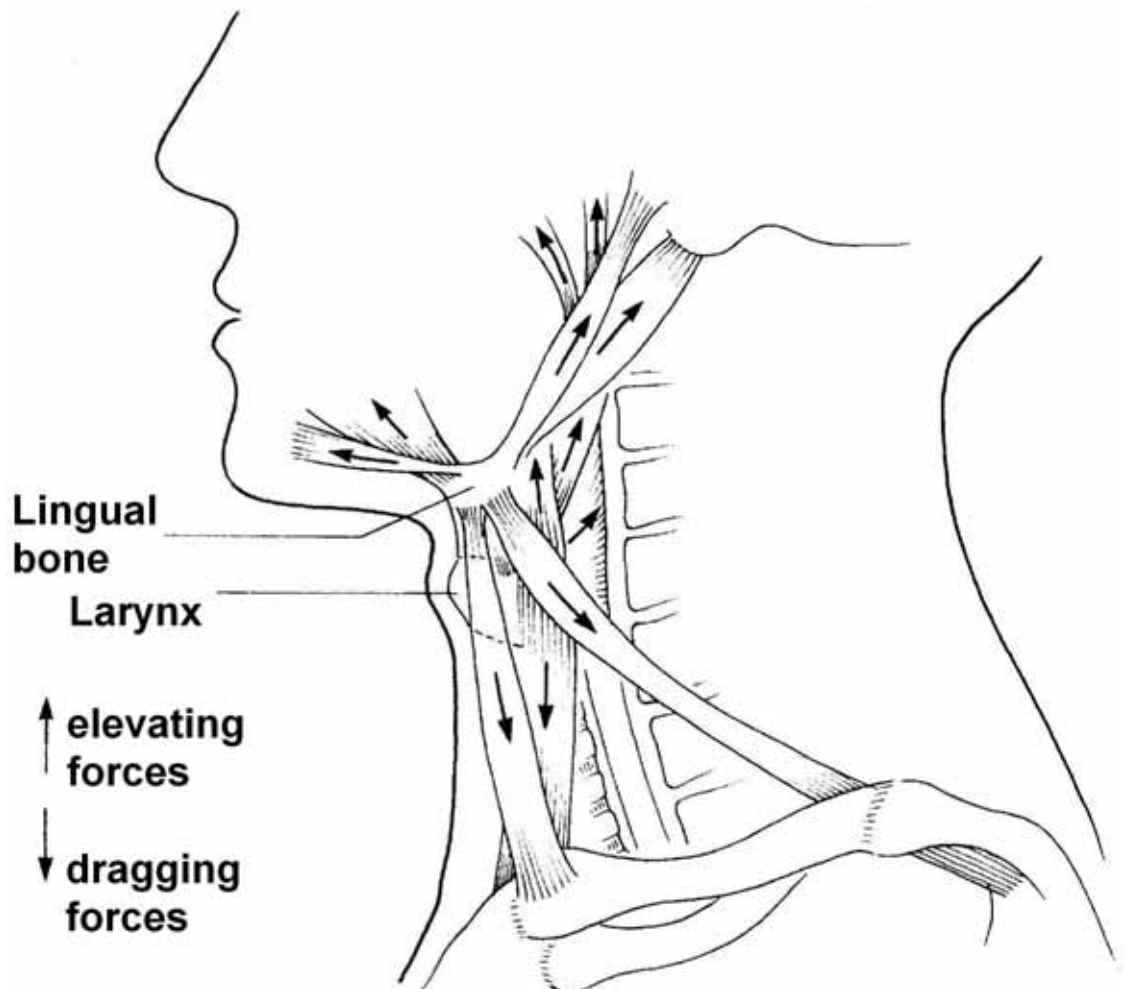
increase problems like functional dysphonia. A significant lowering of the average speaking fundamental frequency may indicate vocal fold pathology.

The basic voice-tone is the pitch at the end of a sentence. He is in accordance with the relaxed level of the so called chewing voice (deep, full voice, relaxed vocal folds, larynx goes down). Usually he vibrates about a third under the fundamental frequency. In the complete relaxed state he can even go lower, because as a rule the voice tends to drop in a relaxed condition. In this moment, when the larynx is in bottom position, the basic voice-tone has the same frequency as the vocal folds as Wirth (1991) and Scherer (1986) noticed.

Since it is generally known, that all muscles of the body are connected to the larynx by the large superficial and deep muscles and vice versa, a high muscular tension influence the larynx. The result is a higher voice level when we are stressed and a lower level when we are tired (Cramer 1998 b). During the low position of the larynx all other muscle systems are in a “relaxed” position as well. That means: in regard to the basic voice-tone that we apply a tone that mirrors somehow the sound of the relaxed muscle system.

FIGURE 6. Extrinsic muscles of the larynx. Like the rays of a star the muscles of the larynx point radially to all directions of the bodyFrom

Cramer (1998). *Das Buch von der Stimme. Ihre formende und heilende Kraft verstehen und erfahren.* Zürich, Walter, p. 38



To determine both individual voice tones there are several possible methods:

- inner humming of the pitch and adjusting it immediately on the instrument;
- inner humming of the pitch and comparing it to a tuning fork – I use a tuning fork tunes to g (194, 18 Hz), that is a convenient basic tone to deduct from;

- let the client hum and match the pitch on the piano (the method of the laryngologist);
- in case of uncertainty I put the instrument next to the body and push the bridge centimeter-wise up- or downward and ask the client, which tone he/she likes best;
- the simplest way is the use of a software, which shows within one or two minutes the both important voice-frequencies³.

TABLE 3. Main differences between individual speaking fundamental frequency and individual basic voice-tone

| | Individual speaking fundamental frequency | Individual basic voice-tone |
|-------------------------------------|---|---|
| How to hear it out | <ul style="list-style-type: none">• the average pitch at which one speaks• the most used frequency while speaking | <ul style="list-style-type: none">• the pitch at the end of a sentence• usually the most relaxed acoustic energy in a person's voice |
| The mechanisms in the larynx | <ul style="list-style-type: none">• between ergotropic and trophotropic=overall relaxation of vocal apparatus and respiratory system• increased salivation | <ul style="list-style-type: none">• trophotropic dominance with hypotension of the musculature in the vocal apparatus and respiratory system• the vibration rate of vocal folds corresponds with the frequency of the basic voice tone |

TABLE 3. Main differences between individual speaking fundamental frequency and individual basic voice-tone

| | | |
|-----------------|--|---|
| The spectrogram | • frequency at lower end of range | • low frequency and low frequency range |
| | • low amplitude to moderate amplitude | • low amplitude, formant-frequencies tending toward neutral setting |
| | • balanced resonance with slight decrease in high frequency-energy | • broad bandwidth of the first (lowest formant) |
| | • adult females vary between 165-256 Hz (e-h) | • at a rule a minor or major third lower than the individual speaking fundamental frequency |
| | • adult males vary between 87-131 Hz (F-c) | • adult females vary between 147-220 Hz (d-a) |
| | • child speech ranges from 250-294 Hz (a-d') | • adult males vary between 73-110 Hz (D-A) |
| The frequency | | • children vary between 175-262 Hz (f-c') |

The instrument comes, by the way, immediately in resonance with the body, when the tone has been correctly selected.

There are plenty of discussions, whether the basic voice-tone is consistent. According to my experiences, it is not. It depends

- on the age
- on the physical and psychological condition
- on the speech content

3. A software is presently developed, which is going to make it easier in the future for the therapist to determine the basic voice tone and the speaking fundamental frequency, and in addition to measure the voice range and to notice deviations in the vocal range, that do not correspond to the norm. This will be of special interest for music therapists and such therapists, which employ the therapeutic monochord in the frame work of hearing and voice therapy.

- on the environmental noise

With women I found a range for the basic voice-tone tone between d and a (most frequently e, f, f sharp and g) - with men between D and A (most frequently E, F, F sharp and G). Hence all 25 strings of the instrument are tuned on the basic tone, the instrument is put on the body and the client admits in exactly this tone. He hears and feels a tone that perhaps corresponds to his relaxed muscles. It is possible that, according to Pontvik (1954), a kind of “psychoresonance” takes place: *“The psychoresonance comes up to the well-known rules of physics and acoustics: material comes in resonance with other material, when the vibration rate is conform.”*

Pontvik is herewith picking up from the “universal law of vibration” of the Dutch scientist Christiaan Huygens. Huygens stated in 1665: two pendulum clocks, hanging next to each other on a wall, initially oscillating asynchronously, begin to resonate in a short time to each other. And they maintain exactly their pendulum stability, far more beyond the measure of mechanical possibility. They swing in the same rhythm. The synchronization is caused by a weak impulse, transferred from one clock to the other. Physics called this later the “mutual phase locking of two oscillators”. It is a phenomenon with universal validity. A reason for this can be seen in the fact, that nature is always looking for only the most minimal energy condition. To oscillate in harmony needs far less energy than in disharmony.

Most of the clients can feel the vibrations of the monochord = their basic tone, especially strong in the tense parts of their body (the “out-of-tune” parts). After a prolonged and repeated playing the vibrations can move on and expand within the body and finally it results in the feeling: my body is my sound. The fundamental frequency is not as deep as the basic tone and therefore physically not so precisely to feel. It leads to an energy between tension and relaxation with a tendency to relaxation.

It would be premature to interpret statements from clients, but I still want to mention a little experiment, carried out in all training groups, that shows in an amazing way the obviously existing sounds that fit exactly to all of us: I divided the groups into smaller ones consisting of three persons each. One was lying down, the two others played for him a tone, the basic tone and another arbitrarily selected one. The person lying down was not told beforehand, which tone was played. But he was immediately able to identify “his” tone. Even if the arbitrarily selected tone was only a quarter tone above the basic tone or in a harmonious constellation, like the fifth, each one knew immediately which tone was his basic tone. This experiment shows us repeatedly, how delicate the work can be with the single tone, because it

happened frequently that the second arbitrarily selected tone could cause displeasure or even pain.

The Tone-Transfer-Therapy can be applied to all three fields of music therapy (an overlapping occurs in all fields):

1. in the orthopaedagogic music therapy
2. in music medicine and
3. in the psycho-therapeutic music therapy

The Tone-Transfer-Therapy in the orthopaedagogic music therapy

Van Uden, who proved 1955 impressively in his practical work with deaf-mute children, how distinct the vibratory sense can be, speaks here of “resonance feeling”: The sound vibrations, transmitted by air, are especially felt in the chest. Some of the sound producers are brought into direct body contact. This is what van Uden calls “contact feeling”: The sound waves are transmitted through body contact with the vibrating medium, e.g., through the foot soles that are placed on a vibration-conducting floor, or through the finger tips and palms that touch a radio, loud-speaker or instruments. A large role in the orthopaedagogic music therapy plays the sound as vibrating element and therewith as physical experience. Sound instruments are therefore frequently such instruments that can combine hearing and moving, hearing and feeling, hearing and touching, and which can therewith, among others, support speech ability. When a vibrating sound producer is held close to the body, its vibrations can become perceptible to the client. The monochord can be one of these sound producers.

Even deaf persons can participate in acoustic events through their vibratory sense. Piel (1983, 156) states: “*The natural parallels between music and language offer best-possible starting points for hearing disabled persons for the correction of speech melody and speech rhythm, and therefore for the comprehension of speech ... The vibratory sense seems often so subtly developed, that the differentiation of intervals in the size of a half tone (!) presents no difficulty ...*” It “*...can, however, be used for initial speech training, a fundamental aim of a school for the deaf, whereby music instruments serve a good purpose. The deaf can well perceive the vibrations preceding from membranophones. With the help of these sound tools accents in word and sentence structure can make sense.*” That is why children can

learn with the help of their vibratory sense to react to sound colours and to develop a sound-differentiated language.

In my work with hearing impaired people it was remarkable to see, how the audiogram changed after auditive exercises and treatment with the Tone-Transfer-Therapy. 94,4% of 18 patients with partly severe hearing problems showed a better audiogram. The hyperacusis decreased: at the beginning of the therapy 61,1% complained of partly severe hyperacusis, at the end 11,1% suffered a little under hyperacusis, 88,8% didn't suffer any more (Cramer 2002a).

The therapeutic monochord can serve as an instrument of hearing therapy in the orthopaedagogy music therapy. Hearing therapy is the procuring and grasping of "elementary sound phenomena". The hearing therapy consists mainly in hearing- and perception exercises, that support the hearing and vibratory sense and have additional pedagogic value. Hearing therapy can also be designated as music education with hard-of-hearing and hearing-impaired children and adults, or as "support of auditive perception". It is an overarching aim to make the world of speech as well as the sound of music accessible to concerned people. Hearing therapy in the sense of music therapy must be differentiated clearly from hearing education and training. The latter belong to the area of hearing-impaired pedagogic.

The Tone-Transfer-Therapy in music medicine

There are three outstanding attributes of the T-T-T:

1. the induction of deep relaxation
2. the pain reduction
3. the support of body awareness

Among the many functions of music in our everyday living the leading to relaxation is probably one of the most important one, whereby the meaning of relaxation is very complex.

Relaxation should be separated from depth relaxation. Only then content and purpose can be made clear. Relaxation is a condition that can be reached with a walk, fine meal, movie viewing, dancing, garden work, knitting, etc. Whoever wants to relax with music, does it according to his own taste: marching music, pop music, techno or classic music. In these cases music is effective according to the law of pleasure principle, in the sense of a regressive, relaxing experience. Depth relax-

ation presents an involution of relaxation. It requires in general a verbal instruction of the therapist. After some practice it can be carried out as an auto-suggestive technique. Music and sound become the medium on the way into the depth of relaxation. They should therefore not be offered simultaneously to the initial verbal instruction, but afterwards. Music helps to abate external stimuli, respectively to eliminate them.

In general, quiet sounds are selected, that do not reach a relaxation effect by way of previous tension, but through dropping oneself into the music or sound immediately. Once the outer and the inner world begin to harmonize, there arises inner rest, pleasant silence. In most cases it lasts only a few minutes until a patient comes in relaxation with the Tone-Transfer-Therapy, mainly because of the monochromatic sound.

Deep relaxation starts after 7 minutes (Linke 1977), before that time limit digressive associations, pictures, afterglows and daydreams reveal. That's why the therapy with the therapeutic monochord should at least take 10 minutes.

The loosening effect of music-supported depth relaxation can reveal conflicts and problems. But this is not the primary purpose of music medicine. Here the sound has the task to relieve the affect and to make him live through, respectively to dissolve him. The appropriate conflict content remains as a rule unconscious. If, however, there is still the desire – after listening to music – for a talk, then it helps in general to complete the still insufficiently remaining affect removal and to smooth the affect. If the affect relief is so strong that conflict contents appear, there should be a clearing verbal therapy afterwards (Cramer 2002b).

The mechano-cutaneous stimulus has also a healing effect: the stimulus can be carried from the body surface on the nervous system. Already a general massage in a quiet tempo and rhythm has a calming effect, and additionally the soft vibratory stimulus to the skin offers “*a very special effect towards psychical relaxation and prepares therewith for a healing conversation*”, Putkammer (1953, 56) states.

Amazing is the vibrotactile effect for stroke patients. In severe cases they have paralyzed parts of the body (mostly on the right) and suffer under extremely tenderness up to pain. With the therapeutic monochord we have the possibility to put it directly on the concerned parts. Because of the high sensitivity of these patients they can feel the vibrations much more intensive than others. If I put the instrument on the foot soles they feel the sound through the whole body up to the top of the head. The muscles can relax within minutes and the new feeling for the up to now usually, idle, numb and all the same hurting part of the body can change in a comfortable

and pleasing impression. This experience is so important for these patients because at the same time new neural linkages are created, which make it possible to feel, use and control the concerned parts of the body as the work with stroke patients showed.

The Tone-Transfer-Therapy in the psycho-therapeutic music therapy

The monochord has already for a long time found its place as psycho-therapeutic procedure in music therapy. The client listens into the specific sound of the monochord. Behind it stands a specific purpose, for example the induction of trance, the support of associations, the dissolution or the new structure of self-awareness and coenesthesia or a support of body-awareness (Cramer 1999).

Frequently I am using the therapeutic monochord to train a new lost body- and psychic perception. The need, not only to hear sounds, but also to feel them, increases in a world of rising lack of contacts and deprivation of one's own perception. Young persons raise benefit for themselves through a high noise level, because they can feel their bodies through the beat from the speakers.

The body perception can be approached by all forms of sound transmission, especially if the sound comes from only one sound producer. Low tones up to 40 Hz are perceived mainly in the lower extremities, the higher ones in the head. Since many clients are preoccupied with their heads it is recommended to start with low tones and noises and to train the vibratory sense, in order to transmit a feeling for the body. Haerlin (1998, 241) describes, how strongly the body structure and therefore the consciousness for the own body can be altered: *“A lanky, physically not very integrated patient, whose parts of the body were almost fragmented and lying around as those of a puppet, reports proudly after 20 minutes of Monochord playing, that he has more body, and that it feels more adjusted.”*

The best way to become aware of body perception, of own purposes, of inner needs is a sound offer that has little stimuli and little substance as possible. Then the client can reflect himself, mirror himself in the space of sound.

The main effect of the sound experience is to support sensible and empathic emotion and physical perception and this can only happen, if music per se does not prescribe an emotion or a substance like, for instance, in program music. This sensitive listening presupposes concentration and opening of all senses, a procedure that can

lead to essentially stronger vegetative changes, than if a listener simply drifts away with the music. Katz and Révész (1958, 137) report about feelings that appear when one turns from mere listening to vibratory perception: *“One becomes aware of a strange change: the transposition from the outer to the inner; while the musical tone is always located in the outer space, the localization of the vibration can be felt in our own body. One could say that the tones are drawn into the inner of the body, they are closer to the coenesthesia.”*

Through the fine vibrations the muscles can loosen themselves. A firm body becomes relaxed, heavy and sinks as it were in the ground, or it becomes light and transmits a feeling of floating in the air. The sound can also settle itself at a certain part of the body, the patient feels clearly his blockade or his tensed muscles: *“The vibration has spread itself to the foot soles, but it could no longer reach the head, it was kind-of choking me,”* a patient reported who was suffering from strong tension in the neck muscles. In several sessions he could learn by a kind of “musical bio-feedback” to loosen the tight muscles, to let the sound pass through the whole body. This self awareness can only be perceived, if the patient learns to connect his outer with his inner ear. Since most patients are unaware of their vibration sense, it is eminently important to follow the trail of sound and vibrations afterwards – in a quiet, relaxed condition.

In this state, when the patient is left alone for about 5 minutes, he should remain by his inner ear with the sound experience and feel what has been changed within his body, how vibration movements move on, how the lymph was effected, how the cells vibrate in the after-effect, whether needs, feelings, memories have arisen: the inner movement must be traced and manifested.

A special quality offers the Tone-Transfer-Therapy in connection with the **Guided affective imagery, a mental imagery in short-term psychotherapy**, developed by the German Hanscarl Leuner (1994)⁴. It influences the imaginations in three therapeutically valuable directions:

- the rich overtone sound stimulates the associative flow of pictures;
- the accompanying feelings and affects are clearly activated, which causes frequently feelings of being deeply moved;
- resistances in the imaginations can be given up easier by the support of sound.

Leuner (1974,192): *“I am succeeding with this method to bring patients to a depth-psychological treatment, those that were formerly considered as untreatable. They are either rather ‘simple’ personalities ... or ... very conservatively inclined per-*

sonalities which have lost the access to their own world of emotions, the so-called 'emotional illiterates'⁵.

The harmony, that reminds of the origin

The sound perception by the monochord in music therapy is generally described as "oceanic spread of the ego". However, according to my experience, this cannot be confirmed. Indeed, each client perceives the sound differently – a fact which could be explained thereby that the therapeutic monochord is only used in individual work and only with a very individual tone. During the treatment the intensive vibration causes in the pelvis the feeling of being "grounded". This is the absolute opposite of "oceanic spread of the ego". That could be because of the basic tuning of the instruments, which do not exceed the limit of 200 Hz, a frequency that corresponds to intrauterine noises and sounds and a frequency that can be felt intensely in the body. With these low sounds especially the areas of the cortex are being addressed, which lie outside of auditive surface – for example the motor cortex or the sensory cortex; whereas the auditory cortex is mainly stimulated by the high frequencies (Cramer 1997).

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4. Hanscarl Leuner was a professor for psychiatry and neurology, at last at the university of Göttingen/Germany. At the edge of the scientific literature he found references how to evoke daydreams in a conventional psychoanalytic couch setting. In the consequence he started a set of experiments over the relations of self emerging symbol constellations in the mental imagination and internal basic conflicts of a person. Meanwhile he discovered the effectiveness of psychotherapy combined with led daydream techniques. Experiences thereby led to the **Guided affective imagery** psychotherapy, as well in the combination with simple trophotropic sounds. Leuners ability to observe extremely sensitive and to describe intra-psychological processes very subtle, enabled him, to use these imaginations systematic for the stimulation of emotional catharsis. This was quite the contrary to the at that time usually verbal-cognitive oriented psychotherapeutic procedures. The Guided Imagery and Music is a further developed technique, in a personal dialog I had with him, Leuner demurred however about this technique, it could be too violent and thereby it is a misunderstanding of his method.
 5. = Alexithymia, a psychosomatic disturbance, the patients confuse emotions with weakness

The compound between the low basic voice-tone – which presents something familiar for the client – and the high sound spectrum, that spreads itself through the over tones, can lead to unique auditive and vibration experiences.

A special quality of the instrument can be found in the fact, that only one tone is repeatedly played. Pfrogner (1976, 240 ff.) states about the repetitive prima: *“Of the intervals prima, octave, quint, quart, the prima is the principally most significant ... The repeating prima shows up in each instant the renewal of the coenesthesis, the new creation, the thread of the ego. Just as the tone itself the repeating prima can be designated as the embodied remembrance ... The most inner encounter with the ego corresponds to the prima experience, the original confirmation of one’s own creaturely being...”*

In 1637 Marin Mersenne, French mathematician, music theoretician, philosopher and monk, writes in his work *“Harmonie universelle”*: *“The spirit begins to enjoy the music of the blessed ones, when he hears the unison, that reminds him of his origin and of the beauty, for which he is hoping and waiting.”*

Conclusions

With instruments, which can transfer vibrations into the body the music therapist has a mighty tool in his hands. Besides the mostly positive resonance on his vibratory couch, from which came music from Bach, Teirich describes impressively and also frightening how some single patients reacted (1958, 136): *“It should not be kept a secret that up to now there were two incidents: a psychology student ... appeared at my office in the morning of the next day, showing signs of severe anxiety and said the following: ‘Your couch is like Klingsor’s magic bed; it has a terrifying effect. I was unable to sleep all night and had a most severe anxiety attack. I felt tied down on your bed and could see myself as in a mirror.’ The condition of the patient was worrisome indeed, and I was afraid – based on his record – of a schizophrenic attack. After corresponding treatment his anxiety decreased within three days, the patient remained inconspicuous and passed recently his exams successfully.”*

A female patient told Teirich after the vibration experience (1958, 137): *“‘It was incredibly horrible. I had real anxiety attacks.’ When asking her why she did not get up, ... she answered: ‘I felt electrified, it was impossible to get up.’”* Teirich does not dwell on these two cases. He also does not go into the past medical history of the psychology student. I assume, and this is an essential point, a) that he used

the same music for each patient (the Dorische Toccata und Fuge), hence did not select the suitable music, and b) he was obviously unaware, that patients with psychic illnesses could be swamped with the combination of hearing and feeling.

My colleague and I had a similar experience: severely unstable patients cannot cope with vibration exercises. In two corresponding cases the monochord caused traumatic memories: a female patient at the age of 76 was reminded of war times with bombing attacks, something she had – until then – successfully compensated (the sound of the monochord reminded her of sirens), and, in a 54 year-old female patient, claustrophobia broke through, of which she was unaware until then. Psychologists treated both patients and they were able to overcome successfully their traumata, brought to light by sound experiences.

Leuner also warns expressively to work trance-inducing with clients who have any suspicion of a neurosis, psychoses or depression. Strong and irksome emotions and affects like depression, abandonment, “morbid” disintegration etc., can be provoked. This is, Leuner explained us in a teaching seminar, neither desirable nor necessary. In such cases a therapist should draw the line and not act irresponsibly.

Much at the Tone-Transfer-Therapy is and remains speculative. That is on the one hand unsatisfactorily, on the other hand however it shows, how mysterious and powerful the medium sound is, and that there are things in this world, which will probably remain always hidden. In the music-therapeutic work responsibility must remain highest requirement. Overly quick we bend for self over-estimation, if we see, what we can ignite. But we must always realize that it is not really us doing something for the change, it is the client with his body and his soul, who changes. He is the one, who knows where the shoe presses, he determines the direction of the process. As therapists we are the companions, which go some steps with the patient on the same pathway and perhaps we can still hold his hand for a while. The aim of the pathway, the purpose, its condition, its length and its environment determine the client.

For further instructions in the Tone-Transfer-Therapy® please contact

"accord" PO Box 200216, D 80002 München, Germany

Fax: 0049-89-1708636

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CHAPTER 13

Humanistic music therapy

Cremaschi Trovesi, Giulia & Scardovelli, Mauro

The “Humanistic Music Therapy” term comes from the several outcomes we had during years of hard work, discussions, study and verifications.

Starting from the idea of music as the “art of sound” that helps people to a creative expression of themselves, it is possible to think to man as a “being in the world”.

Every human being, adult or child (sane or with disabilities) is always the main character of his life.

Working inside the Humanistic Music Therapy model means that for us every person (client) is accepted, loved and respected; we try to bring out the capabilities from client’s difficulties and limits.

We can affirm that the basis of our work inside the Humanistic Music therapy is the overcoming of the general judging attitude towards people acts.

An example will help us to explain better the value of this statement.

More than ten years ago, Giulia started her experience with a one year deaf child, she met him trying to approaching him to the sound world without taking care of

his impairment. Giulia “listened” to his gesture, to his attitude, to his each mimic expression telling the personal child way to discover and receive sounds.

She discovered a new world:

- First of all, the discover of the perceptive processes (proceeding from the Latin *per-capio* that means “receiving from my self”). Every perception is a complex event and it concerns the emotions. Every perception is a perception of the world around, that means a “relation *in* the world”, and it also means a knowledge that needs to be constantly renewed.

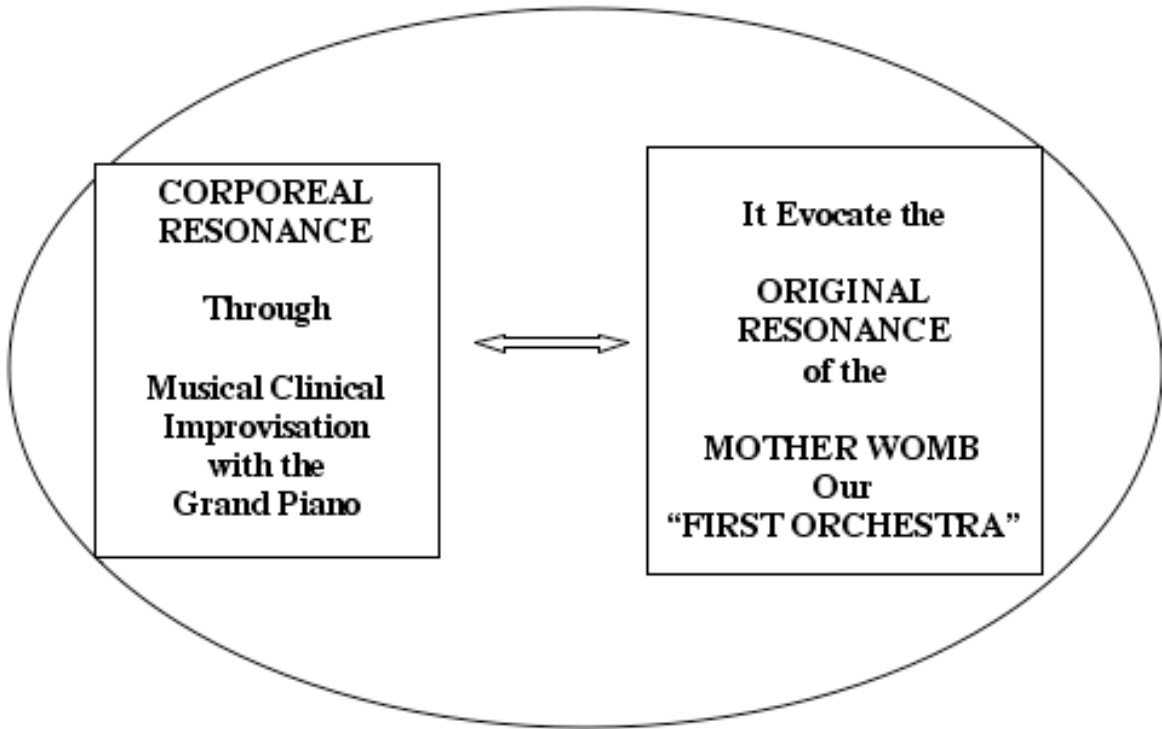
Deaf children don’t hear but they learn how to listen, they learn how to tune their voice, how to play music, they learn how to identify sounds with the eyes covered by a little masque. Finally children can learn how to express themselves with music.

Music Therapy introduces the concept of *Vibrating body*, a concept that can complete the Husserl body concept of the body as “*korper*” (the physical, the anatomic body), the body capable to feel emotions, the corporeal scheme that is in relation with the world around. Humanistic Music Therapy introduces the concept of *Vibrating Body*.

- Giulia Cremaschi could also prove the great importance of the Clinic Improvisation at the grand piano that helps children to the immediate discovery of sounds and music. The piano revealed its powerful possibilities to make bodies vibrate. Bodies with severe impairments as deafness, traumas, cerebral palsy, strong tensions (autism) etc.

Music was born with human being. The maternal womb is our “First Orchestra”; it is the place where it does not exist a moment of silence, where music is constant pulsation, breath, voice and emotions. It is our first meeting with life. This “First Orchestra” it is an “unconditional holding”, it is a will of life, it is a total absence of judge.

FIGURE 1.



Every human being living this “First Orchestra” starts learning how to move because someone is moving him, learns to talk because is *con-vibrating* in the resonating emotional sounds of the maternal body.

Once born, the human being will find again in the world the same vibrations and the same emotions known in the liquid transmission but now under a new way: the aerial transmission. So that we can affirm that every knowledge is not entirely new, it is only a way to meet again a world once knew but in a larger world.

Now every single event will happen inside the relation with the others; but in life there are relations that can help the harmonic growing up and others that can block or restrain it (as traumas usually do).

Music exists in each culture and in each historical period, because sounds are the texture of original relation, the original contact, our “First Orchestra”.

Through different ways to “make” music, human beings keep expressing the original emotions of their life.

- “Con-vibrating” in the Original Resonance means being moved and cradled to learn how to move.
- “Con-vibrating” in the Original Resonance means making the experience of the rhythmic and motor order. This experience will be applied to numbers, measures etc.
- “Con-vibrating” in the Original Resonance means the experience of singing, the experience of the mother voice, of the words, it will be applied in learning to talk.

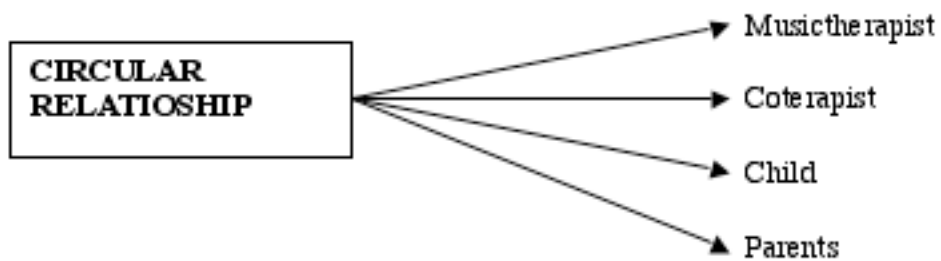
Looking for the connections between Music and Bodily Resonance we can find the theoretical basis of humanistic music therapy:

- the theory
- the epistemology of music
- The “why”, “how” and “when” of music therapy.

The difference between the Humanistic Music Therapy Model founded by Giulia Cremaschi Trovesi (APMM model) and the others approaches has to be seen in the strong theories based on music.

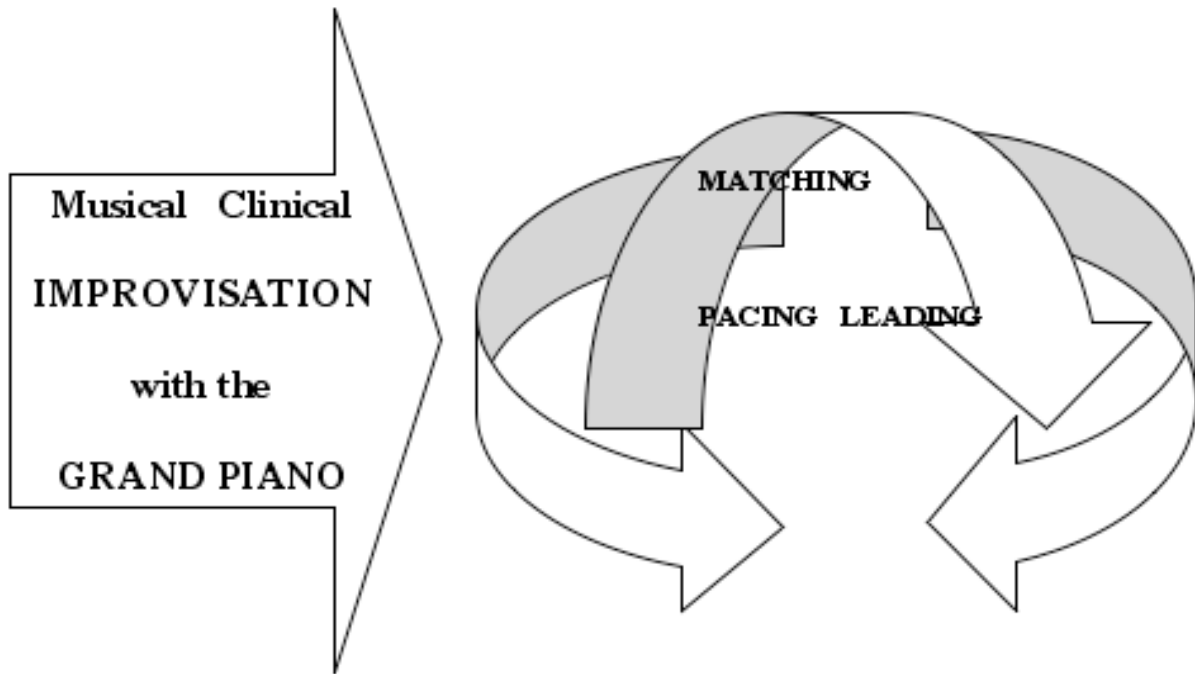
Her model has been built with the collaboration of Simona Colpani (the Circular Relationship Model) and by Dr. Mauro Scardovelli (the Humanistic Neuro Linguistic Programming approach).

FIGURE 2.



1. Corporeal Resonance
2. Sound Dialogue (*Dialogo Sonoro* in italian, a Mauro Scardovelli method).
3. Clinical Improvisation with the piano

FIGURE 3.



These three points are strictly connected, one inside the other.

The Corporeal Resonance is possible only through the harmonic chest of the grand piano

Like every instrument of work, the grand piano should be used with care.

The client lying down on the piano chest can benefit only when he/she is ready to listen to the direct sounds. Every person capable to listen can answer to the piano sounds through the entire body (the Vibrating body).

The music therapist plays the piano making improvisation, changing and calibrating each sounds and texture on the person, the music therapist try to establish a sound dialogue with the person through the piano.

This Dialogue is always different, even if the patient doesn't play any instrument, music therapist can have a dialogue as well by "reading" and changing in music improvisation his non verbal communication: gestures, mimic expressions, energetic tone of the body, breath etc.

The music improvisation is also a clinical improvisation because it is based on the difficulties of the patient. The purpose is to reach the patient by giving value to the difficulties he/she shows and to help the patient to use the inner resources coming from the relation established between patient and music therapist.

MUSICAL EPISTEMOLOGY

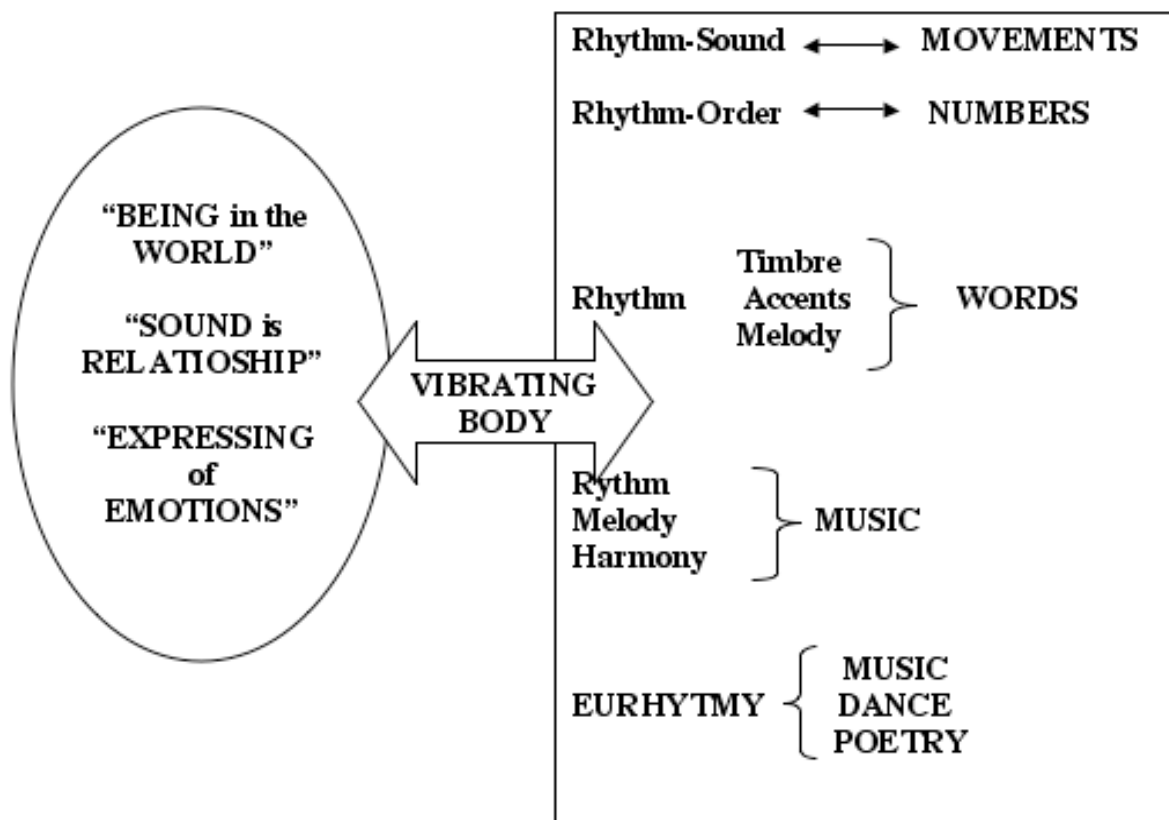
The Musical Epistemology is the basic element in Humanistic Music Therapy.

There is now a considerable literature describing music therapy sessions with severe impaired patients where we can assist to moments of strong and spontaneous participation.

Once we reach this specific and intentionally purpose what does it happen? What does we can affirm?

It is evident that experiences with music therapy go very far. We can affirm that the Vibrating Body that means the attitude "to listen to" or to be present to reality but living the reality inside a non-verbal communication helps the coming out of verbal communication.

FIGURE 4.



The relation existing between sounds (vowels) textures (consonants) and the spontaneous and natural coming out of words should be a part of music therapist knowledge.

Voice flows from the breathed air, the very original way to be a part of the world.

Breathing is what it makes come in and come out from the "vibrating body" the world with we are in relation.

Through the “Bodily Resonance” we are able to modify the general quality of the bodily tone, reaching a more harmonic breathing that finally can come from a spontaneous relaxation.

Breath is order: each movement, each gesture is in the breath.

Breath is voice. Musical notation is a powerful tool to help the patient become aware of his/her “being” in the world, in his/her “vibrant and alive body”.

Musical Pedagogy

The APMM model (Giulia Cremaschi Trovesi Musical Pedagogy and Music Therapy Association) comes from the study of the experiences of Dalcroze, Willelms, Montessori and Laura Bassi.

The aim of the musical pedagogy is a harmonic growing up of the person through the listening and the musical practice.

Singing and playing are the useful tools to know us better inside the relation with the others and the world.

The musical notation is (as it happened in history of music), the first instrument to help the child to be aware of his vibrating body, of his breath, of his voice and of the movements of the voice related to the space-time order.

As we all can notice, our children receive an excess of stimulations that took them to have lacks of attention or to be too much excited.

They mix up the use of electronic components with the notion of music. The “making” music can help them to find the profound value of listening to themselves, to the others and to encourage them to feel respect for their learning.

The listening requires coordination between ear, eye, and hand. It helps to take care of the gesture and to give attention to the connections between sounds (heard and played) and the written signs.

Through the “making” music the creativity that every child has comes out.

But creativity can develop only together with learning and it can be a useful way to develop the self-esteem and the esteem for the others.

Only taking care of us can help to put attention to the others needs, so that we can solve problems of aggressive attitude in our classrooms by playing together, a way to consolidate new relationships.

But we also have to put our attention to the body as the centre of the human being.

It is important “to read” the body’s children, its non-verbal communication as the very communication by which children communicate us their troubles and lack of self- confidence.

At least we can see that APMM Musical Pedagogy agrees with Humanistic Music Therapy because they are based on the same epistemology.

CIRCULATION RELATIOSHIP

In the cases of children with different severe pluri handicaps we use the circular relationship.

Sometimes we can preview that some clinical situations can only degenerate so that’s why we use sounds through Corporeal Resonance and the Clinical Improvisation at the piano, that permit us to observe better the children reactions.

The APMM model is based on the music therapist observation while playing the piano, at the same time the co-therapist receives the child inside a direct contact body to body.

So the child with severe impairments is “wrapped” into a complex resonance: the sound waves hugging the child (body-piano) and the hug of the arms of the co-therapist (body-body). The co-therapist can touch the emotive tone of the child body and try to understand the child’s intentions and needs.

Children with severe palsy would like to move the body but the movements are difficult, the co-therapist is capable to read this while the music therapist improvising at the piano help the movement to come out.

This approach helps the child to prove new experiences.

Also the use of others little musical instruments (some of them expressly constructed by the therapists) encourage the development of the movement, of the knowledge of the world.

Parents (at least one of them) are usually presents to the therapy so that they can share with their child the same experience.

Child difficulties become resources that can open new thoughts, ideas to share with.

Child difficulties become the resource that can explain the value of the life.

While the child starts experiencing the world can also give vent to his/her memories of pain and sufferance. The therapists give values to his outlet leading the child to a new life, a sort of rebirth.

This way of proceeding gives successful outcomes in cases of child autism.

Observation in Music Therapy

The understanding of the “non-verbal” communication is the important part of the humanistic music therapy.

The Sound Dialogue arises from the immediacy of the non-verbal communication. The music therapist replies by playing to the child each single gesture, movement or simple intentional gesture of communication.

The relationship between the therapist and the child exists since the very first moment of the meeting.

What the child does has a meaning and the music therapist gives values using the clinical improvisation at the piano. The music therapist follows the emotions with a sort of “imitation” giving the possibility to other emotions to come out.

The body of the client “talks” and tell what words can not still tell. The body of the music therapist takes, listens and answers through the musical improvisation.

Body is breath, it is emotive tension where gesture and communication can develop. It is not important the beauty of the gesture, what it is important is that the gesture has the possibility to exist. The task of the music therapist is to transform it

into something communicative. By this way of acting the client has the possibility to prove new emotions, something that never happened, something unexpected, we can assist to the birth of the “surprise”. It is like starting a new journey.

Change is the aim of therapy.

The main character of the music therapy is the client who decides to change himself in his own way to see life.

In the clinical improvisation at the piano we can assist to a total absence of the “judge logic” (the concept of Husserl *epoché*). The person tells us emotions by the arms, the hands, the tension inside a movement, the possibility of change.

Voice has to be listened with a musical attention and care. A voice that is “out of tune” reveals the need to come back to the order, to the intonation. The intonation is also proportion in the body, the intonation is to be seen in the tensions and in the movements.

So it is important to affirm again that the observation in music therapy is something that reside inside the relationship:

- playing while observing
- observing while playing
- observation is relating to someone. In other cases it wouldn't exist dialogue.

The body of the client is the partition from which the music therapist takes the ideas, giving sense to each little and almost “invisible” thing that comes from the vibrating body of the client.

It can not exist a contraindication for the use music.

If music is the art of sounds, music therapy is the art of communication.

In the APMM Model Musical Pedagogy and Music Therapy are strictly connected; every child should learn how to listen. A child learns how to listen if he feels that someone he is “listening” to him. Only by that way he can listen to himself.

This is a therapeutic and educative process at the same time.

Music therapist should use his/her inner resources to help the person to have a constructive experience with the sounds. Through experiences can develop a dialogue.

The most interesting experiences can be seen with persons to whom music and the listening should be impossible: deaf children. Music therapy with deaf children opens new routes to understand better the verbal language. Speech emerges spontaneously and naturally in deaf children when they find again (with the interaction with the others) their natural vibrating body.

Deaf children teach us how strong is the presence of sound in the human being living in the world. Word is inside the deaf child. But deafness can prevent the development of speech. The Resonating Body helps deaf children and autistic children to listen. But in cerebral palsy too, the same method can help bodies to a spontaneous relax.

It should be clear that this method goes far the concept of physical rehabilitation.

The training in Music Therapy

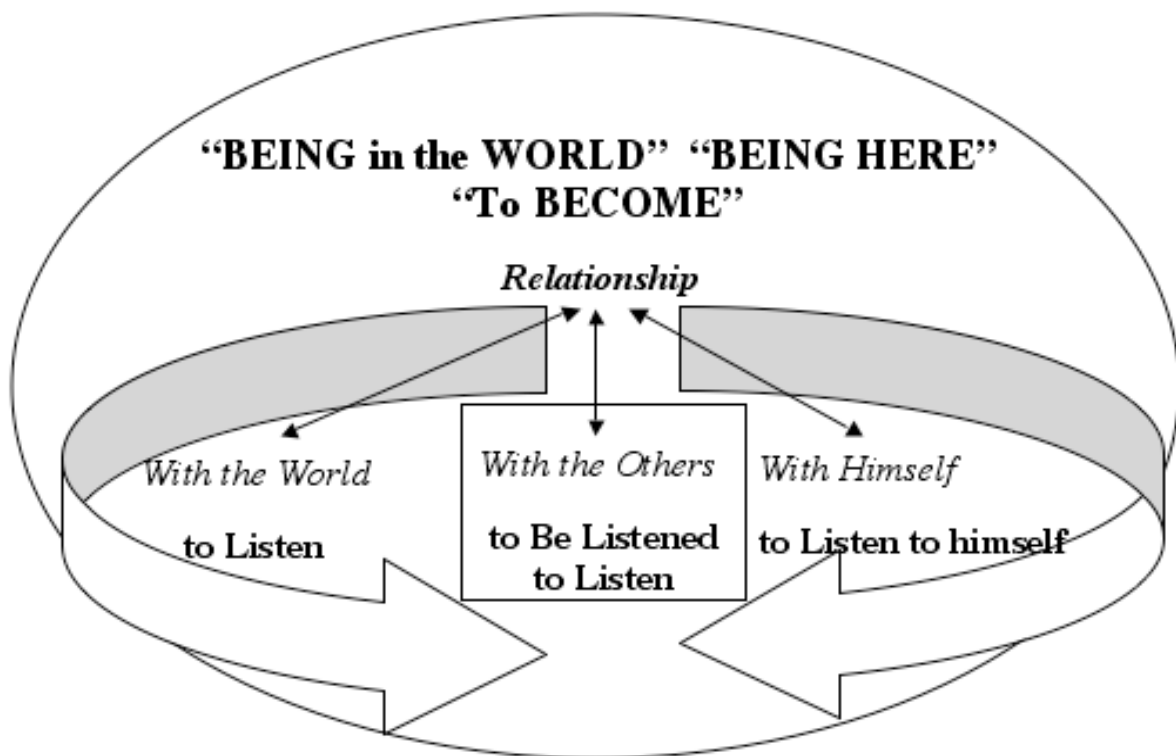
In the Humanistic Music Therapy model there are different levels of specialisation:

- the Music Therapist: a therapist trained to work inside medical hospitals, outpatient clinics, day care treatment centres, for groups interaction, and the special needs of the elderly with different neurological impairments (Parkinson, Alzheimer etc.). Music therapists also work for developmentally disabled persons centres, community mental health centres, for drug and alcohol programs, for pregnant women, senior centres, hospice programs, schools.
- “Music Therapeut” (*musicoterapeuta* in Italian): a therapist who has received a more complex training: both psychological and musical. The “music therapist” is qualified to project and follow a therapy working individually or with a small group of 2 or 3 persons. He/she is able to work with the adult of child emotions to guide the person to a therapeutic change. The main tool is the musical knowledge: improvisation, composition, the use of the musical elements such as: rhythm, melody and harmony with a therapeutic aim.
- The co-therapist: a therapist who has a humanistic degree because humanistic music therapy has its basis on the phenomenological ideas. But the co-therapist should have also musical knowledge to be able to interact with the “music therapist”.
- The educator should be a “music therapist” with strong and long experience. The educator has different competencies in communication to report with public

and to help the apprentices and the other music therapists inside the supervisions meetings.

- Founders and leaders of the School: the ultimate responsibility of what I am saying is committed to three persons: Giulia Cremaschi's Humanistic Music Therapy APMM denomination and theory. The Humanistic Neuro Linguistic Programming is committed to Mauro Scardovelli. The Circular Relation has been founded from Simona Colpani as "co-therapeut".

FIGURE 5.



Conclusions

Humanistic Music Therapy APMM model needs a constant inner growth to develop the fundamental principle: every patient brings inside the therapy its history that meets the music therapist history. From their very first meeting starts a new path for both.

This idea leads directly to an other principle: first comes the person, after there is the pathology, a music therapist dialogue with *the person*.

That's the reason why there is no such thing as an overall typical session; events are always unknown and reach of new elements.

The correlation is fundamental condition for a dialogue. Music therapist discovers the Vibrating Body through the difficulties of the patient.

Limits are the obstacles that we meet, from a *phenomenological* point of view, we can affirm that difficulties are at the origins of our inner resources.

The inner resources come out with the help of the Dialogue, which is the musical play that gives the singleness to each meeting in music therapy sessions.

It will never happen the same event because subjectivity in each singular emotive and perceptive process is unique. It is also the reason why *the person* needs and likes a next *meeting*.

Humanistic Neuro Linguistic Programming

In the music therapy training, education can be divided into two fundamental aspects:

- education to learn efficient strategies
- personal education

In both cases our psychology model is the Humanistic Psychology which we defined as: *Humanistic Neuro Linguistic Programming* founded by the Italian train-

ers Mauro Scardovelli and Carolina Bozzo. The HNLP started from the fusion of the NLP innovative techniques about communication and mental processes of learning.

We found the same theoretical and moral principles of the Humanistic Psychology and Transpersonal model, at the same time they integrate the original ideas of Bateson from which NLP started in the 60-70's.

Between all the models we can say that music therapy is one of the possible therapies to integrate. NLP can give a strong contribute to music therapy by searching through the observation the more significant patterns and procedures.

NLP can helps researchers to understand which is "... the difference that really makes the difference". In this way methodology can become stronger and precise.

Through HNLP, (keeping our ethical principles and values) we wish for a future where music therapists will have the possibility to grow up and evolve.

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CHAPTER 14

A different kind of work: music therapy in children's hospices in the UK

Cubitt, Gill

Introduction

Unlike most music therapists in the UK, I work in a children's hospice; this has provided me with the context and motivation for my first piece of research, which I am going to talk about today.

Before I describe this research I think that it's useful to explain what children's hospices aim to provide. Here is a definition of palliative care for children:

- An active and total approach to care
- It embraces physical, emotional, social and spiritual elements
- It focuses on quality of life for the child and support for the family
- It includes the management of distressing symptoms, provision of respite and care through bereavement
- It is provided for children for whom curative treatment is no longer the main focus of care and may extend for many years
- (ACT/RCPCH 2003:6)

Background to the Research

So why did I decide to do some research? I will try to draw together the various strands, which led to this decision.

Firstly, there is my own work in a children's hospice in rural Norfolk, where I have worked for almost four years, beginning shortly after qualifying as a music therapist in 2000. There are six beds, five for respite, one for emergencies. There's a wide age-range (0-21) and also a wide range of medical conditions. Each week I offer music therapy sessions to all staying/visiting the hospice, including other family members. Flexibility over when sessions take place, who comes, and how long sessions last is important due to the changing needs of each child.

However, this was very different to my experience of music therapy whilst training. On placement as a student I had experience of organising regular weekly sessions, at the same time and place, with an individual or a group. The flexibility, which was necessary in the hospice, seemed to require a different way of working, which was difficult to think about. I wondered whether other music therapists working in children's hospices also experienced this work as different and challenging? Perhaps they had changed aspects of their work? I decided that I needed to conduct some research. As most of the music therapy work in children's hospices in the UK was originally funded by the charity 'Jessie's Fund'¹, this group of music therapists would be the focus of my research.

The Research Questions

I decided to investigate the following research questions:

- What is different about this work?
- What is challenging about this work?
- How have music therapists changed how they work in response to these differences/challenges?
- How have music therapists been changed by the experience of working in a children's hospice?

1. Jessie's Fund, 10 Bootham Terrace, York. YO30 7DH

These questions arose out of reflections on my own work, and also from unanswered questions raised by other music therapists writing about work in palliative care settings

Salmon's paper (2002) 'Death and the Music Therapist: Coping with Ongoing Loss and Suffering' (presented at the World Congress in Oxford 2002) inspired this piece of research. In it, she identified the first research question as being worthy of research.

Other music therapists such as Hartley (2001) and Rykov (2001) who also work in palliative care settings had described challenging aspects to their work. However, there had been no systematic research into the experiences of music therapists working in children's hospices.

The questions about change arose from my own work. I had made changes to how I thought about and organised sessions in response to the changing environment of a children's hospice; I also found that I was using a wider variety of musical interventions in response to the children's needs on each day. Perhaps even more significantly, working with ill and dying children was having an impact upon many different areas of my life, both personally and professionally. I wanted to find out whether this was happening to other music therapists in the same situation

I hoped that finding answers to these research questions would enable me to say 'This is what this work is like'. Perhaps I wanted hard answers to difficult questions....

The Research Design: A Survey Method

I chose to use a questionnaire as the main means of gathering data; this would enable all music therapists working in a children's hospice to contribute to the research irrespective of geographical location. It would not be feasible for me to interview all music therapists working in children's hospices; however, a small number could be interviewed before designing the questionnaire. Making use of both interviews and a questionnaire seemed a good solution, also advocated by authorities on questionnaire design such as Gillham (2000:19-21). Gillham explains that using semi-structured interviews as the first stage of questionnaire development can be a useful means of 'honing in on a particular topic and also picking up specific ways of phrasing topics and questions' (2000:21).

WHY CHOOSE A SURVEY METHOD?

So why was I keen to use a questionnaire? As an ex-teacher, a questionnaire seemed attractive, as it required clear thinking and good organisation. At this stage I wanted some hard answers to difficult questions! It was also a practical way of finding out the opinions of all music therapists currently working in a children's hospice.

However, in my newer role as a music therapist, I was becoming more reflective in my approach; perhaps this explains my interest in more qualitative methods?

Using both interviews and a questionnaire seemed like a good compromise; I hoped that making use of both quantitative and qualitative methods would make the research more valid, by providing 'data triangulation'.

So the first stage of the research was to interview four music therapists currently working in a children's hospice. They were all asked the same set of questions; interviews were tape-recorded and notes were also taken. Three women were interviewed and one man; all signed a consent form. They were all asked the following questions:

- What differences, if any have you experienced in your music therapy work in a children's hospice, compared to music therapy work in other settings?
- What challenges, if any have you experienced in your work in a children's hospice?
- What, if anything, have you changed about the way in which you work with the children in the hospice?
- How, if at all, have you been changed by the experience of working in a children's hospice?
- What else would you like to talk about, with a view to it being explored in a questionnaire?

After the interviews had been conducted, a simple content analysis was performed, as follows:

- Subjects were coded P1-P4
- All statements were condensed & word-processed
- Statements made in response to each question were grouped into categories
- The categories were used to form item banks in the questionnaire.

THINKING ABOUT THE INTERVIEWS

The data from the interviews was very absorbing and had yielded some rich & moving data. Here are just a few of the statements:

Differences:

‘Each session should be regarded as complete in itself, as the child may die any-time’ (P4)

Challenges:

‘It is a creative, emotional, physical and spiritual challenge’ (P2)

‘The unpredictability of when a death will occur’ (P1)

Change:

‘More flexible about using different types of music e.g. backing tracks’ (P3)

‘More flexible about who comes to sessions and number of sessions a child has’ (P1)

‘Have developed a philosophy of life and death which incorporates music’ (P4).

At this point in the research what had I found out?

- All subjects agreed that the work was different and challenging
- Emerging themes were uncertainty found in hospice work, and the personal and spiritual impact of this work
- Significantly, all had been changed in some way by the experience of working with ill and dying children
- The data had an emotional impact on the researcher
- The process of analysing the interview statements was difficult to end

DEVELOPING THE QUESTIONNAIRE

The first version was piloted and abandoned- I had made the mistake of trying to use all of the comments made in the interviews, so it was far too long. The final version was in four sections:

- Questions exploring differences
- Questions exploring challenges
- Questions exploring changes

- Subject descriptors such as gender, place of training etc.

Designing the questionnaire was surprisingly difficult and time-consuming!

THE RESULTS OF THE QUESTIONNAIRE

Eleven questionnaires were returned; a high response rate, representing around sixty percent of the total sent out. Each questionnaire was coded, with R1 being assigned to the first one returned, and so on up to R11 for the last one received. Certain questions required a simple content analysis; for these, the same method was used as was utilised on the interviews. The small size and exploratory nature of the survey led me to conclude that a simple descriptive analysis was the most appropriate treatment of the data. The subject descriptors will be presented first, as they are the only factual information; the remainder of the questionnaire was designed to discover opinions.

The Findings

(N.B. Here, a series of graphs was shown, which have not been reproduced in this paper.)

There were two male respondents and nine female. Out of the eleven respondents, only two had been working as a music therapist for over ten years; this seemed to indicate that relatively inexperienced music therapists are choosing to work in a children's hospice.

The respondents came from a range of training backgrounds, with four out of the six UK training courses represented.

Section A was concerned with the first research question, which was about the work being different. When asked for levels of agreement with the following statement:

- Working in a children's hospice is different from other music therapy work

(Q1), there was strong agreement; all respondents either strongly agreed or agreed that working in a children's hospice is different from other music therapy work.

Question 2 consisted of an item bank containing a range of differences, and an instruction to tick all which the respondent had experienced in their own work in a

children's hospice. All respondents indicated that they had experienced the following three differences:

- The organisation of sessions
- The large client-base, with a diversity of medical conditions
- The wider role of the music therapist.

This suggested a high level of agreement amongst the respondents. Furthermore, nine of the respondents had experienced 'the degree of uncertainty surrounding the work' as a difference, and seven had experienced 'greater involvement from other staff' (which is still over fifty percent).

Five of the respondents selected 'other' amongst their range of responses, and wrote their own descriptions of other challenges experienced. The emotional impact of this work can be seen in some of these comments, such as R1 who described the 'diverse and rapid changes' in the 'emotional environment', and R11, who wrote of 'the emotional impact of clients losing skills'. The uncertain nature of the work was perhaps implied by R6, who wrote of 'ad-hoc involvement of families/parents/siblings', and also R8, who referred to 'lack of continuity in the sessions'. When asked to indicate which of these differences was the most significant (Q3) there was less agreement. Three respondents chose 'The wider role of the music therapist' and three selected 'The degree of uncertainty surrounding the work', as being the most important difference. Of the remaining five, two selected 'The organisation of sessions', two chose 'The large client-base, with a diversity of medical conditions' and one selected 'Other', and wrote 'The lack of continuity in the work/ the much larger time-scale of the work'.

Question 4 asked respondents to indicate how they organised their music therapy sessions in the hospice. Subjects were asked to tick up to two boxes out of four, making ten possible responses. The modal response was of organising sessions on an 'open' basis, along with some regular appointments.

None of the respondents organised their sessions on an 'appointment only' basis. However, in a setting such as a school, appointments would be the norm; the way in which most of the music therapists organised their sessions in the hospice is a notable difference.

The last question on the theme of 'difference' posed the following statement:

'The knowledge that each session may be the last is a significant difference' and asked each respondent to indicate their level of agreement on a scale. The majority

of respondents either agreed or strongly agreed with the statement, with only two of the respondents disagreeing. This high level of agreement seemed to indicate that being aware that the child may die at any time marks this work out as being different from other music therapy work.

Section B contained a series of questions written to explore the theme of challenges experienced by the music therapist. Firstly, respondents were asked to indicate their level of agreement with the following statement:

- Working as a music therapist in a children's hospice is challenging.

All respondents either strongly agreed or agreed with the statement. Everyone who had returned the questionnaire had found this work challenging; the researcher wondered how the other music therapists who had not returned the questionnaire would have answered this particular question. However, there was the possibility of respondent bias; (Robson (2002: 172, quoting Lincoln and Guba, 1985) would any of the respondents have wanted to say that the work was not challenging?

When asked to indicate which of the challenges (given in an item bank) they had experienced in their work in a children's hospice, each respondent indicated at least two challenges. This in itself seemed to indicate the difficult nature of this work. Nine out of the eleven respondents had experienced personal challenges. Eight had experienced challenges arising directly from the children's medical conditions, and eight had experienced challenges arising from uncertainty; again, this was a high proportion of the respondents. Just over half of the respondents had experienced challenges arising from staff relationships, and just under half (five) had experienced spiritual challenges. Three respondents also selected 'other', and wrote their own description of other challenges experienced.

The descriptions of other types of challenge experienced were interesting. Both R1 and R6 referred in some way to the wide range of musical input required. For example, R1 described 'very broad demands, both personally and musically' which seemed similar to R6's description of 'challenges from the diversity of musical input required on different occasions'. R8 seemed more concerned with how the sessions were perceived by others, especially the teenage clients. R8 wrote:

'To make the music therapy attractive to the teenagers; to "suit everyone", or rather, to advertise my sessions within the hospice'.

The next question in this section (Q 8) asked respondents to indicate the most difficult challenge, using the item bank from (Q7). There was a range of responses. Four respondents selected 'challenges arising from uncertainty' as being the most

difficult type of challenge, three selected ‘challenges arising from the children’s medical conditions’ and three selected ‘personal challenges’. This was interesting as these three types of challenge were selected the most frequently in the previous question. One respondent indicated ‘other’ and wrote,

‘The challenge of adapting daily to what may be required- no routine- e.g. individual child/parents and family/siblings/involvement of staff- I suppose this relates to c)’.

The last question in this section (Q9) asked respondents for their level of agreement with the following statement:

‘The emotional impact of the death of a child is particularly challenging’.

There was no disagreement with this statement; five of the respondents agreed and six strongly agreed.

Section C looked at the theme of change. The first question in this section (Question 10) asked respondents to indicate how their range of musical interventions had changed since beginning this work. Eight out of the eleven respondents indicated that this had increased, two reported that their range of musical interventions had decreased and only one said that it had stayed the same. Perhaps the general increase in musical intervention arose from some of the challenges reported in the previous section?

When asked whether they had changed how they thought about music therapy (Question 11) nine out of the eleven answered ‘yes’ and only two answered ‘no’. In other words, eighty two percent of respondents felt that their thinking had changed.

Question 12 asked respondents to describe how their thinking about music therapy had changed. Nine out of the eleven respondents wrote comments; as these were quite long, a simple content analysis was carried out, using the same method as before.

The largest category to emerge was of a broader/wider concept of music and music therapy within this particular work situation. Six statements seemed to fall into this category. For example, R2 wrote of ‘the wider role of music-how music reveals a common humanity’ and R6 wrote,

‘In a hospice the music therapist’s role can be very wide,’ and went onto explain something of this role:

'E.g. the therapy for the child, a facilitator for the family, a sense of release for the staff'. Some of the comments in this category were both amusing and moving, such as R8's:

'Music therapy has broadened in my mind because of the nature of the work at the hospice. I now include a range of musical experiences into music therapy (concerts, encounters in music). The human contact in a session has become the most important thing. I think my ideas of music therapy have broadened (I hope so!).'

The next category to emerge seemed to be a notion of becoming more flexible, or open-minded. This seemed similar to the previous category. R4 wrote of becoming 'more open, flexible, greater degree of spontaneity and "Go for it" approach,' and concluded with 'enjoy work more', which seemed encouraging. R11 also wrote of being 'more flexible and open. Perhaps to look at each individual in a music session, rather than to have set boundaries around each person'. There seemed to be a sense of opening up and expanding in both of these categories.

The third category was also about expansion; it seemed to be about the place of the ill child within the family and hospice community. For example, R1 wrote of 'being therapeutically involved with families, staff, etc'. R6's comments seemed to imply some sort of teaching role on the part of the music therapist:

'Music therapy may also involve showing the parents/carers how they can use music as a way of being with their child'. R9 also wrote some thought-provoking comments about the ability of significant adults to use music as a means of making a connection with the ill child, and also of the relevance of music therapy for other family members, for example, 'when a child is at the hospice for terminal care'.

The fourth category was named 'Changes to theoretical perspective'. In a sense, all of the written responses to question 12 could be categorised thus; however only one person (R10) made an explicit reference to a particular theoretical model, writing that 'sometimes psychodynamic thinking is inappropriate'. This was tantalisingly brief; the researcher would have liked to know more about why the therapist had reached this conclusion.

The last category was labelled 'Other' for comments hard to place. For example, R1 wrote of being involved in fundraising and PR; perhaps this was a further example of expansion of the music therapist's role? R10 wrote that medical procedures were more important than sessions, and concluded by writing that 'Thought can be given how sessions can be arranged around these procedures'.

The next question (Q13) asked for levels of agreement with the following statement:

- One long-term development has been an increase in awareness of the spiritual needs of the children and their families.

Interestingly, only one respondent disagreed with this statement, whereas two strongly agreed and eight agreed. This seemed an interesting finding, which may merit further investigation.

The final question in this section (Q14) gave respondents the opportunity to describe any significant changes to their own personal or spiritual development. Six respondents wrote comments; this was over fifty percent of the total number of respondents, which seemed a surprisingly high number. Furthermore, many of these comments were long and rather complex, which perhaps indicated the difficulty in thinking clearly about such an ambiguous term as personal and spiritual development; it may also indicate that the question was not clearly written. The comments were again treated to a simple content analysis. There seemed to be five broad categories emerging:

Firstly, comments about personal growth or development, such as R4 who felt that they had become 'stronger-more open-emotionally secure', which seemed to be a positive development. R1 also reported personal growth, which seemed to emerge after resolving difficulties with other members of staff.

Secondly, spiritual growth, such as R1 again, who felt that spiritual growth kept them 'aware of the simple fundamentals and how the peripherals are irrelevant'. There was a sense of spiritual exploration, such as R4 who had become 'freer with spiritual and emotional exploration'.

The respondents appeared to have their own spiritual needs as well as greater awareness; this was the third category of comments. R6 had needs which seemed to be connected to the fears of the children and families:

'How can their fears be met? What fears does it bring out in us, and how does our spiritual life help us face them?' R1's comments seemed to touch upon the wide-ranging meaning of all things 'spiritual', writing:

'Stronger central awareness of spiritual connection and spiritual needs; means and modes very secondary'.

The fourth and largest category of comments seemed to focus around issues concerning death and dying. Four respondents mentioned this in their comments. R5 found thinking through 'life and death issues' challenging, and also recognised that

they needed 'time to grieve'. The responsibility inherent in helping vulnerable families to face 'the unthinkable' was highlighted by R6, who acknowledged that they were 'searching for purpose and reassurance'. The fragility of life, and the need to work 'for the moment' was touched upon by R8, who also wrote that they 'think about death and dying a lot; it affects my day to a varying degree'. R9 seemed to be looking for answers to very difficult questions when they wrote,

'My own personal "quest" is to try to find answers to the question of whether individuals choose to die; this is a very big one'. Processing so many references to death was also challenging for the researcher.

The fifth category of 'Other, for comments difficult to categorise, also contained some interesting comments. R6 mentioned the possibility of having to look elsewhere for help for the family to cope, and R8 touched on questions of medical ethics, such as 'Is it right to have medical intervention to keep very disabled young infants alive?' This seemed very controversial; R8 confessed that they did not 'know the answers to these biggies'.

Any Answers?

So what did I find out? Did I find out hard answers to difficult questions? Conducting research turned out to be more complex than I had imagined; however it seemed reasonable to conclude that:

- There was a high level of agreement throughout this survey
- There was a significant change to how I viewed the data gathered in interviews, I now wanted to think of it as part one of the research
- What makes this work different? There was no single answer, but the impact of working with the dying emerged as an important theme
- Working with wide age-range of children, with wide variety of medical conditions emerged as both a difference & challenge
- A questionnaire format was not flexible enough to explore emerging links-perhaps further research was needed
- Impact of working with ill/dying children, & high level of uncertainty led some music therapists to ask searching questions about their own belief system
- Wider role of MT led to the development of new working practices & new ways of thinking about the work

- The researcher found the process challenging and changed her thinking during the course of the research

And Finally...

I had discovered something important about myself during the process of conducting this research; that of feeling connected to the therapists who had taken part. It was as if the findings could only be experienced as being 'true' if they were experienced emotionally, not just intellectually. Adam Phillips (1998:55), writing about Winnicott, came to mind:

In a talk given in 1950 to psychology and social work students, entitled 'Yes, but how do we know it's true?' the British psychoanalyst D.W. Winnicott suggested that there were two stages people always go through when they are taught psychology. 'In the first stage', he writes, 'they learn what is being taught about psychology just as they learn other things. In the second stage the psychological teaching begins to separate out from the other as something that just can't be learnt. It has to be felt as real, or else it is maddening'.

Phillips goes on to explain what happens in the second stage of the process (1998:56):

'Each student, consciously or unconsciously, makes something of their own out of it all; finds the bits they can use, the bits that make personal sense'. I realised that I had been trying to find the bits, which made sense, which felt 'real'. What did emerge as 'real' after this difficult and challenging process was the impact of working with the dying. This theme emerged as central to the work; the impact of working with ill and dying children set it apart as being different, provided the greatest challenge, and caused many therapists to ask searching questions of themselves, leading to both personal and professional change.

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CHAPTER 15

Music therapy in medicine: creative collaborations in palliative care

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The past two decades have seen the emergence of intense interest in music therapy in palliative care and cancer care. This has included descriptions of music therapy interventions and research of various types to identify the effectiveness of music and music therapy (Aldridge, 1996, 1998, & 1999; Bailey, 1983; Beck, 1991; Beggs, 1991; Boldt, 1996; Bundt & Marston-Wyld, 1995; Burns, Harbuz, Huckelbridge, & Bunt, 2001; Curtis, 1994 & 1989; Dileo, 1999; Forinash, 1990; Gallagher, Huston, Nelson, Walsh, & Steele, 2001; Hilliard, 2003; Hirsch & Meckes, 2000; Krout, 2000; Lee, 1995; Logis & Turry, 1999; Magill, 1993; Magill Bailey, 1984; Martin, 1989; Munro, 1984; Munro & Mount, 1978; O'Brien, 1999; O'Callaghan, 2003 & 1996; O'Callaghan & Colegrove, 1998; O'Callaghan & McDermott, 2004; O'Kelly, 2002; Rykov, 1999; Sabo & Rush, 1996; Schroeder-Sheker, 1993; Standley, 1992; Thematic, 2001; Walden, 2001; West, 1995). This interest in

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the potential of music to improve lives of those in palliative care has captured the imagination of not only music therapists and health care professionals, but of the public as well.

This paper will describe a unique palliative care program which taps into the public's interest and the music therapy profession's expertise to create an exciting new collaborative approach. While a brief introduction to the initial pilot project will be outlined in this paper, there will be a forthcoming publication which provides a detailed description of the permanent program, with a manual for those wishing to establish similar programs in their community (Curtis, 2004).

The Collaborative Project

Music Therapy in Medicine was a pilot project established to improve the well being of palliative care patients of a large regional hospital in Canada through community-based collaboration between a symphony orchestra and a university music therapy centre. The university music therapy centre had been building a reputation for its focus on building healthy communities through collaborative efforts (University of Windsor Music Therapy Centre, 2004). The symphony orchestra had established a national reputation for community outreach. There was an interest in expanding this to healthcare in general and palliative care in particular. A collaboration between these two organizations offered considerable potential in tapping into the expertise, interests, and resources of both.

Within the pilot project, music therapy teams were created, each comprised of a symphony musician and a university student music therapist. This structure provided unique benefits to all involved. For the student music therapist, it provided a unique opportunity to work with a professional symphony musician; for the symphony musician, it provided a unique opportunity to experience a very different facet of music; and for the palliative care patients and their families, it provided access to high calibre music therapy services.

GOALS

The goals established for the pilot project were: 1) to establish a successful pilot project with input at all stages from all parties involved – the patients and their families, the healthcare team, the symphony musicians, the student music therapists, and the coordinating music therapist; and 2) to establish a best-practices permanent

program using the results of the pilot project. The goals established for the palliative care patients were: 1) to enhance the healing experience, 2) to improve quality of life, 3) to increase access to music therapy, 4) to increase relaxation and comfort, and 5) to facilitate patient and family self-expression.

PROJECT IMPLEMENTATION

The Music Therapy in Medicine Pilot Project was implemented in five stages: Stage 1: Preliminary Work, Stage 2: Team Building, Stage 3: Training & Orientation, Stage 4: Hospital Visits, and Stage 5: Final Evaluation.

Stage 1 involved in-depth consultation between the coordinating music therapist and hospital administrators, health care professionals, symphony administrators and symphony personnel. This stage also involved gathering of such materials and equipment as a 12-track MIDI digital recorder, supportive texts for training, and music. Program brochures, business cards, and all evaluative tools were developed by the coordinating music therapist during this stage.

Stage 2 was dedicated to building the team. This involved careful recruitment and selection of the symphony musicians and the university student music therapists. These individuals would comprise the 2-person Music Therapy Teams which would provide music therapy services at the patients' bedsides. Attention was given to interest, availability, experience, and principal instrument of each candidate.

Stage 3 involved such advance preparation as orientation, training, and press conferences. An orientation was provided to the palliative care healthcare providers with an opportunity for feedback from them concerning design and implementation of the project. Orientation and training was provided to each of those chosen to serve on the Music Therapy teams. As well, inaugural performances by Music Therapy Team members were provided on the palliative care units to introduce patients and their families to the concept of music therapy and to the project itself. Just prior to the actual start of the project, a press conference was held to inform the public and to provide an opportunity to recognize the sponsoring agencies whose funding made the project possible.

Stage 4 marked the actual start of the Music Therapy in Medicine Pilot Project. Each of the hospital's palliative care units received once weekly 2 ½-hour visits from a Music Therapy Team. The team arrived at the unit, met with the charge nurse completing pencil and paper assessments of patients, and visited patients at their bedsides. The length of the individual patient visits varied, being determined by the interest of the patient. Each patient was offered a variety of possible music therapy

experiences from which they chose according to individual preference. These included: music listening; music-centered relaxation; music making; songwriting; and legacy work. In addition to the weekly Music Therapy Team visits, there was also palliative care multidisciplinary rounds which the student music therapists attended as representatives of their Music Therapy Team. Student music therapists also participated in weekly training sessions with the coordinating music therapist.

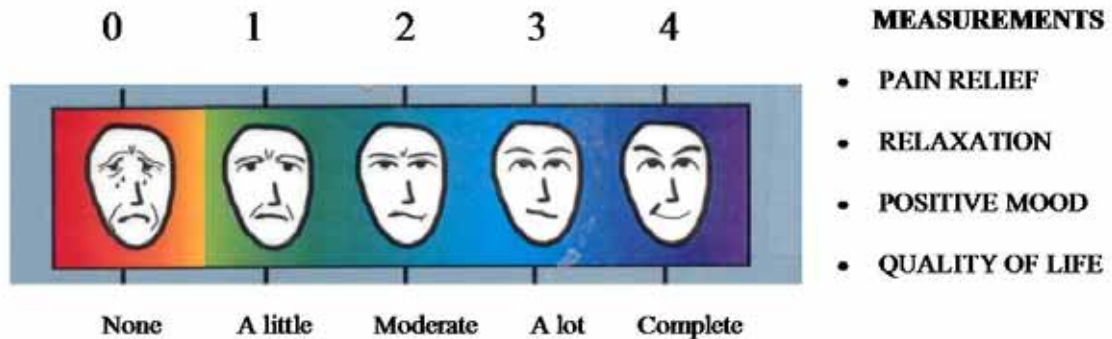
Stage 5 occurred at the culmination of the 3-month pilot project and involved gathering and analysis of all project evaluations. These included data and feedback from all parties involved in the project.

EVALUATION METHODS

Because Music Therapy in Medicine was a pilot project with a primary goal of gathering sufficient information for the development of a future permanent music therapy program, evaluation of the project was extensive and comprehensive. This involved preliminary evaluation of the orientation and training by healthcare and music therapy team members; evaluation at the end of the project itself by healthcare and music therapy team members; Music Therapy Satisfaction Surveys left at the nursing station to be completed anonymously by patients, families, and healthcare professionals alike; and measurement of treatment outcomes with patients.

Treatment outcomes were assessed by means of pre- and post-test measurement of pain relief, relaxation, positive mood, and quality of life using a self-report Visual Analog Scale. This scale was a modified scale of one already in use at the palliative care units. It was hoped that music therapy intervention and evaluation would be simplified in using a measurement tool with which staff and patients were already familiar.

FIGURE 1. Pre- and post-test patient outcomes measurement scale.



Results and Discussion

From all perspectives, the *Music Therapy in Medicine* pilot project was extremely successful. The patients benefitted immediately and significantly in terms of positive treatment outcomes. The patients and their families felt strongly that the music therapy services were beneficial. The healthcare professionals were very receptive to the project, finding that music therapy made a positive contribution as a supportive therapy. The music therapy team members found the experience to be very rewarding both for the patients and for themselves.

VIDEOCLIP 1

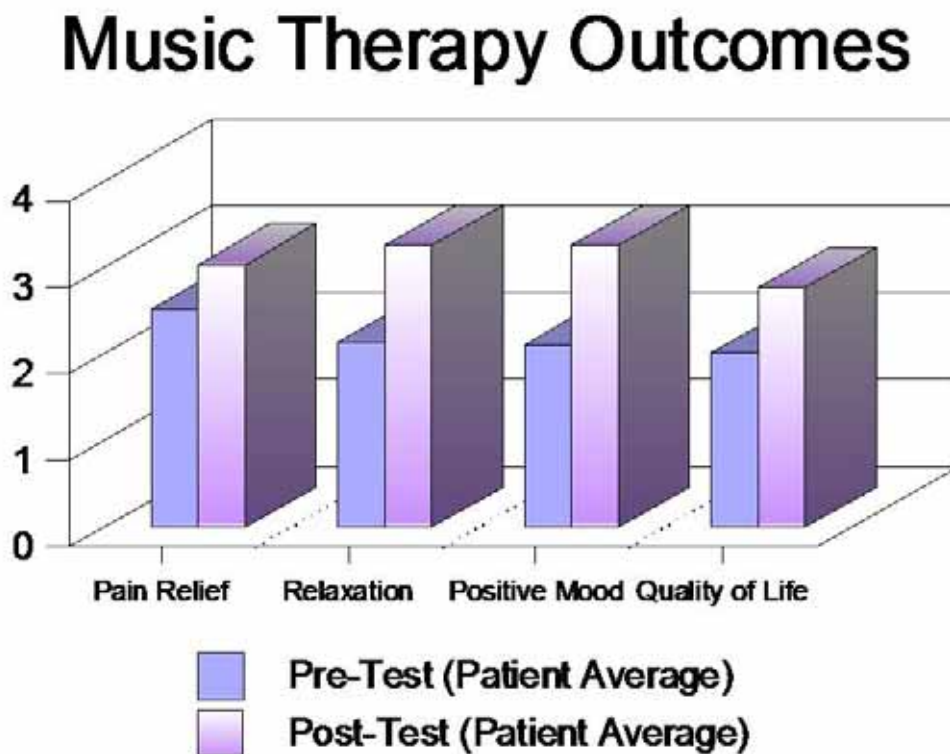


VIDEOCLIP 2**OF THE PATIENTS AND THEIR FAMILIES:**

By the completion of the *Music Therapy in Medicine* pilot project, the Music Therapy Teams had made a total of 20 hospital visits, with 45 individual patient visits. These visits contributed positively to the healthcare experience of the patients and their family members.

Post-test measures showed a significant improvement in all areas – pain relief, relaxation, positive mood, and quality of life (t-test, $p < .01$). Of the 45 patients visited, a total of 37 were able and willing to complete the pre- and post-tests. The following graph shows the average pre-test and post-test scores of all these patients.

FIGURE 2. Music therapy outcomes.



Twelve of the patients involved in the *Music Therapy in Medicine* pilot project completed and returned the Patient Satisfaction Survey postcard. Of those, 100% agreed that the music therapy services were beneficial and contributed positively to the healthcare experience. They were also unanimous in believing that the Music Therapy teams were effective in interacting with patients. When asked to identify the specific benefits of music therapy, 92% identified increased relaxation, 67% improved quality of life, and 25% increased pain relief.

OF THE HEALTHCARE PROFESSIONALS

Of the healthcare professionals who had contact with the Music Therapy Teams, eight completed the Project evaluation survey. Of those 100% strongly agreed that the music therapy experiences made a positive contribution as supportive therapy to the health care experience of the patients and their family members.

OF THE MUSIC THERAPY TEAMS

All of the Music Therapy Team members were able to complete and return the Project Evaluation. Of these six members, one agreed and five strongly agreed that the music therapy experiences made a positive contribution as supportive therapy to the health care experience of the patients and their family members. In discussing the best aspect of the project, they commented:

“Seeing the difference music made in the lives of patients.” – Symphony musician

“Seeing the response to the music. Smiles, laughter, as well as tears all made it worthwhile.” – Student music therapist.

In reviewing the programme evaluations, there is no doubt that the *Music Therapy in Medicine* pilot project was a resounding success. In the minds of all participants, the Music Therapy teams contributed greatly to the well being of patients and their families as they struggled with life-threatening illnesses. Music therapy greatly enhanced the effectiveness of the healthcare experience and all involved felt strongly that Music Therapy in Medicine should continue on an on-going basis.

The final goal of the Music Therapy in Medicine pilot project was to use the information gathered from it to design a music therapy program which would function effectively as a supportive therapy within the palliative care healthcare team and which would be ideally suited to meet the needs of patients and their families. Establishment of a permanent Music Therapy in Medicine program is now underway. Results of this will be detailed in a forthcoming publication. As well, a manual is also forthcoming for those wishing to establish similar programs in their hospitals. This will contain guidelines, orientation and training materials, music and equipment recommendations, thematic descriptions of music therapy techniques and experiences, and a comprehensive set of evaluative tools.

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CHAPTER 16

*How to deal music? Enhancing
coping strategies in music therapy*

*with clients suffering
from addiction problems*

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Abstract

This article describes some of the music therapeutic techniques that the authors use in their daily treatment as music therapists and observation practice with clients suffering from addiction. The article depicts the comparisons and differences between addiction problems combined with psychiatric and forensic ones.

The musical assignments stress the additional value of the action oriented methods of music therapy in comparison with verbal processing. A couple of key-aspects will be addressed such as: addiction, music (therapy), coping strategies, analogy, body-language. The two authors show their specific music therapy methodology, illustrated by examples from their practice in an addiction service respectively forensic psychiatric setting.

Introduction

Clients suffering from addiction are commonly known to encounter major setbacks and problems in their treatment processes. By listening to 'Brown Sugar' from the Rolling' Stones or Techno-House Music they might start craving for heroine or XTC. Yet music is used in a therapeutic way to help clients with substance dependencies to combat their addiction. This article describes such a music therapy program tailored to clients with addiction problems, to tackle some of their major difficulties and specific impairments. The focus is behavioral, intertwined with a cognitive psycho therapeutic attitude to offer a client insight in his¹ behavior and the choice to make changes. Music is used as the powerful tool to encourage people to act (Hakvoort, 2002) and (unaware) show their coping strategies. It touches feelings of longing (sometimes even craving), pain, and pleasure. The bio-psycho-social model is the emphasis in the treatment of addictions. Music therapy addresses upon the underlying psychological and social problems. In this article the focus will be on enhancing coping strategies.

After explaining some of the theoretical backgrounds, we will describe the music therapy methodology. All this will be illustrated by examples of assignments and fragments from cases of the daily practice of both therapists.

1. In this article the authors choose to use the masculine form. Wherever it says he, him, his, man, one can read she, her and woman as well.

View upon Addiction as guiding principal of treatment

This article makes use of different terms for addiction. Partly to distinguish between different stages of consumption (use, abuse, dependency, addiction) and partly to avoid using the term ‘addiction’ too often. There is also a distinction between narcotics (such as marijuana, cocaine, heroine, XTC, medical drug) and alcohol (including all alcoholic beverages). To describe all addictive substances (excluding Cigarettes) the term psychoactive substances is used, to underscore their influence on the psychological perception and reaction of the consumer.

The use of psychoactive substances is widespread. Use can proceed to abuse and might turn to dependency or addiction. The way an addiction evolves is a multifaceted process, always changing and influenced by social attitudes. Formerly there was a major distinction between abuse of alcohol and narcotics. A phenomenon of the last couple of years is the poly-drug abuse, people using stimulating narcotics (‘ice’, cocaine) alternating with downers (heroine, benzodiazepine). The latest ‘trend’ is the addiction to alcohol and party drugs (such as XTC), especially for youngsters. Since addiction is a very complex problem, a single intervention will not yield any lasting result.

The Dutch Health Care Council (2002) reports addiction as an almost chronic illness of bio-psycho-social etiology. Apart from possible brain damage, many addicts are diagnosed with medical and psychiatric disorders, sometimes leading up to criminal behavior.

Most recent views about the treatment of people suffering from substance abuse derive from the idea that treatment can only help a person if there exists a tacit knowledge of the client; his physical conditions, his psychiatric and personality disorders, his life story, his personal and social functioning. If addiction is a progressive pattern of biological, psychological, mental, behavioral and social decline, then it can only be tackled by integrated treatment of social, cognitive, behavioral approach, combined with a medical, psychiatric one.

The bio-psycho-social model

In 1979, van Dijk published a model in the Netherlands, in which he described addiction as the result of a vicious circle of biological, psychological and social

processes leading to addiction. Engel (1980) refined this into the bio-psycho-social model in which multi-dimensional models, derived from different etiologic theories were integrated. The attractive aspect of this model is that it does not only look into the problem of addiction from different diagnostic angles, but offers the opportunity to focus on the relatedness of the different aspects. The assumption is the hierarchy that runs from the smallest systems in an individual (atoms, molecules, cells, organs) to the biggest ones (relations, families, environment, society, culture). The client lives on the crossroads between biology and social context.

The bio-psycho-social model (BPS) organizes the possible interventions that could make up the treatment of clients with problems caused by abuse of narcotics. The advantage of BPS is that it offers a lot of leads for multi disciplinary treatment. Music therapy is just one of the instruments in the treatment of this complex illness. Since the focus of music is on (physical) action, coping, interaction, communication and emotions, it should specifically address the social and psychological components of addiction disorders.

Many of the clients are diagnosed with additional personality pathology, apart from their addiction (Minkhoff, 2001). Most characteristically they depend on restricted and rigid coping mechanisms, which limit their interpersonal relationships (de Jong, van den Brink, Harteveld & van der Wielen, 1993; Verheul, 1997). The addiction itself and the addictive negative influence on behavior are strongly linked to these behaviors. The incapability of handling adequate coping strategies seems to be the trigger and risk factor of substance abuse. (Dijkstra & de Jong, 2003)

COPING

In this article the term coping is used as defined by Lazarus and Folkman (1984): Coping is the manner in which a person reacts (cognitive, behaviorally, and emotionally) to a situation that demands adjustment. Within this context, substance abuse has become an inadequate coping behavior.

The description of coping by an unknown author (2002) gives a glimpse of the authors ideas about coping: People react differently if they have to cope with problematic events. The way a person reacts depends upon his character and the severity of the problematic situation. Each person copes with a situation in his own unique way. Research has shown that disorders MIGHT evolve from long-term or regular exposure to severely problematic situations (Barrett, Doebbeling, Schwartz, Voelker, Falter, Woolson & Doebbeling, 2002).

There are many possible factors contributing to the manifestation of physical and mental disorders. An important factor is the unique way in which an individual observes, interprets and reacts. Every person makes his own judgement of a situation. This determines whether an encounter has been stressful or not. After the judgement followed by the reaction, the coping.

The efficiency of the reaction is determined by situation (duration, context, person, etc.). Therefore it is impossible to set a standard for effectivity of a reaction. In other words: Adequate coping is situation-related. Coping strategies depend on a situation and the stress that appear out of the circumstances. A coping strategy that might be successful at one moment is unsuccessful in another. If the same kind of coping strategies reappear in different situations, it is called coping style. If a person always uses this coping style in strongly differing situations, the coping style is described as rigid.

The Utrecht Coping List (UCL by Schreurs, van de Willege, Brosschot, Tellegen & Graus, 1993) categorizes coping behavior in four major groups:

1. Situation oriented behavior (confrontation, evasiveness, no action → changing the problematic situation)
2. Perception influencing behavior (optimism, accepting, compliance, pessimism, devastation → changing ones reaction by influencing observation and interpretation)
3. Arousal reducing behavior (→ eliminating or diminishing uncomfortable feelings, for example by using substances such as narcotics and alcohol)
4. Expression of emotions

Substances might be used for different coping styles. The use of psychoactive substances can be a coping strategy used to reduce arousal. Another person might use drugs, to confront a situation he otherwise might not have been able to challenge. Yet another might use substances to be more able to express his feelings or to accept an 'unchangeable' situation. But being 'stoned', increases the feeling of inadequacy to act. It increasingly undermines feelings of control and self-respect. Clients show improvement if they can develop their behavior repertoire, which encourages their feelings of self-esteem, self-respect and satisfaction.

Music and body language

Music therapy offers major possibilities to improve and develop coping strategies. Clients have to learn how to deal with (their) emotions, impulses and interactions with other people (Smeijsters, 2000). Music-making forces clients to act. In the action many of their coping styles become visible and audible. If a client is able to get a cognitive hold on these strategies, he might try out alternatives. The assignments given to clients work on the principle of analogy (Smeijsters, 1992, 1993). The basic assumption of analogy is the idea that musical behavior shows major similarities with personal behavior. The analogy process theory, as described by Smeijsters, assumes that actions performed during a specific situation mirror the way a person acts in similar situations in their daily life. Musical behavior may be compared with non-musical behavior. If repetitive patterns of a client's behaviors pop up in different musical situations, the therapist can attribute this pattern to the personal coping profile of the client.

One of the tools to enhance the possibility of discussing these musical behaviors with clients in an unbiased manner, is video-registration during the sessions. It can help the client to review and rehear his (musical) performances and coping mechanisms. In a later stage the video helps to gain insight, reflect upon and evaluate a client's behavior. It can also motivate a client to monitor his or her progress during the (music therapy) treatment. The interpretation of the behavior recorded on video is (partly) based on the principles of Emerging Body Language (EBL) by Rutten-Saris (1992). EBL is based on the idea that every individual has the (sometimes unconscious) capacity to tune in to the rhythm and charisma of another person. The capacity to share sensations without words appears to be fundamental to the way we interact with other people (e.g. Stern, 1985; Rutten-Saris, 2002; Condon, 1977; Trevarthen, 1989). Rutten-Saris distinguishes between five basic interaction structures that develop between a child and its parents. During the first years of a person's life these interactions become implicit neurologic structures, which induce a person to act and cope (Cools, 1985, 1997; Dornes, 1994; Lichtenberg, 1990; Stern, 1985). During the observation (and video-recording) the music therapist and clients focus (partly) on the following five interaction structures:

- Attuning → moving the same way as the other at the same moment
- Taking turns → moving the same way as the other, one after another
- Exchanging → adding new movements while alternating
- Play-dialogue → playing with the expectations forthcoming from the exchange
- Task/theme → Performing a task, or utilizing a theme

The therapist has to engage a client to use different interaction structures and coping strategies by offering different musical assignments and situations while playing. If certain behaviors occur repeatedly during these changing assignments, the client is probably stiffened by a rigid coping style. The treatment will be directed towards enhancing his coping strategies, via music therapy.

Methodology

A considerable number of music therapists have written about the possible goals in the treatment of those who abuse substances (Bednarz & Nikkel, 1992; Freed, 1987; Gallagher & Steele, 2002; Treder-Wolff, 1990). We underline most of those goals and recognize the different interventions. However, in this article we shall emphasize the enhancement of coping strategies, to add a detailed description of a methodology about substance abuse treatment to the literature.

One of the major focuses of music therapy programs is to offer clients an awareness for alternatives for their coping strategies. Before he is able to do so, therapist and client both have to become aware of the strategies that are used. The substance abuse is an obvious one. It is normally linked to other (rigid) coping styles. First sessions are built around the need for the music therapist to observe a client and assess his coping strategies and style. It gives the client the opportunity to get acquainted with music, the therapist and other group members. As soon as there is a working relationship, the therapist helps the client to relate musical behavior to daily situations.

Most of the time these first sessions are held within a group setting. It helps clients to become conscious of the fact that they share the same experiences (Levine, 1982). In an addiction clinical setting it challenges clients to share situations and painful moments. In forensic psychiatry the therapist can switch from one person to the other, which reduces tension in session.

Clients suffering from addiction tend to cling to coping strategies like evasiveness and denial. If we would use a one-dimensional treatment strategy, we would not be able to tackle their problems. Therefore we use an eclectic method focussing on music, coping, behavior, action-oriented, and emerging body language with the bio-psycho-social approach. The musical assignments stress the additional value of the action-oriented methods of music therapy combined with verbal processing. During the process of making music a client has to act. He behaves in a personal style,

fueled by his own strategies and cognitions to act in a certain way (Hakvoort, 2002; Smeijsters, 2004).

The music therapy program

The music therapy program is organized in five different phases:

PHASE 1 INTRODUCTION

The goal of this phase is to create treatment conditions and to get to know one another. This phase lasts one or two sessions. Most of the time we use music listening assignments, to see what musical style or which songs trigger what kind of memories or reactions (such as craving, avoiding). We assess as well what kind of musical and treatment history the client has and how well he can function within a group.

In the first phase clients bring their own music to which they listen together. In this way they have a kind of “safe” introduction with the music as an intermediary. The therapist encourages the clients to have verbal exchange about their music, to get to know each other. It provides the therapist with the opportunity to check if the client is able to listen and analyses the music in a dimensional way; beyond the easy judgement of beautiful-awful. In this phase they can expand in awareness of the effects of music on emotions and feelings. On the social level the client can take the simple step of learning to respect different musical tastes of group members.

PHASE 2 OBSERVATION AND REGISTRATION

The goal of this phase is to record the most important (and rigidity of) the client’s coping strategies by using structured rhythmic assignments. Assignments that are used in the second phase to assess coping strategies are:

Drum circle (rhythmic assignments) .

1. Every patient and the therapist choose a drum. Each plays one beat, together they (have to) form a steady pulse (to assess listening skills, anticipation skills, musical feeling). Therapist stops.
2. The tempo or volume of this pulse is raised or lowered (to assess listening skills, anticipation skills, musical feeling, motor skills). Therapist stops.
3. The pulse has to continue, but now each member can withdraw from the task to play by raising his hand. His neighbors have to play their own single beat, but

earlier (to assess social awareness, attention span, empathetic behavior, anticipation skills). Therapist stops

4. Instead of one beat a small pattern might be repeated by the group. Each person has to start (at least) once. They have to play a rhythm that they expect that everybody else might be able to remember and to repeat (to assess social awareness, attention span, empathetic behavior, anticipation skills, individual cognitive strategies to start a pattern or remember a pattern). The one who started stops first. The clients stop in turn.
5. One person starts with his own drumming pattern. The next joins in with his own drumming pattern, that fits within the first one. Each client joins in, one after another with his own rhythm. In this exercise there is an invitation and assessment of the interaction-structure Taking-turns → moving the same way as the other, one after another (to assess social awareness, attention span, empathetic behavior, anticipation skills, individual cognitive strategies to make up a pattern, strategies to stick to ones own pattern). The one who started stops first and then one after another.

FIGURE 1. Drum Circle (Participants of a workshop at the EMTC conference in Finland)



This exercise determines differentiation in treatment that is focussed primarily on addiction or on forensic issues.

With a treatment focus on addiction, the next step is to stimulate the group cohesion, by Attuning (moving the same way as the other at the same moment).

6. Clients play exactly the same basic rhythm together. Once the rhythm is synchronized the group has to continue to play the rhythmic pattern, while varying in dynamic with the whole group at the same time.

7. Next every client, one after the other, has to play a solo, while the group plays the basic pattern to give the solo a musical foundation. Each member of the group has to play his solo, and can take his own time and make variation in dynamics, pattern and tempo. The interaction structure of this last part is Exchanging (adding new movements while alternating).
8. Finally the clients start with the same basic rhythmic pattern and now they can do a solo if they like, sometimes with more clients at the same time. The interaction structure is Play-dialogue (playing with the expectations forthcoming from the exchange).

FIGURE 2. Drum Circle 2 (Participants of a workshop at the EMTC conference in Finland)



Most forensic clients are not capable of higher interaction structures. They have major problems with empathy. Assignments that follow in this second phase are:

9. As 5, but now they have to come to an end together. One client (after another) is pointed out as the 'conductor' of this closure (to assess social awareness, possibilities to ask for attention, empathetic behavior, anticipation skills, individual cognitive and behavioral strategies to end a situation).

10. As 6, but now there is no assigned conductor (to assess social awareness, possibilities to ask for attention, empathetic behavior, anticipation skills, individual cognitive and behavioral strategies to end a situation).

Example:. The four men participating in this second session for forensic offenders substance abuse group start off slightly nervous. They chuckle a lot. As soon as I give them the first musical assignment of the drum circle, some macho coping mechanisms pop up. They hardly listen to one another and each plays as loud as possible, only concerned with his self. They do not dare to confront one another with any inconvenience (for example the enormous noise) and only tend to discredit one another's musical achievements. During assignment 4, one of them is not able to reproduce the rhythm and becomes the laughingstock of the others. I cut off this behavior and confront each member of the group with their coping styles as shown so far.

Mister C. is playing very dominantly (loud, with all the power of his muscular arms), can hardly listen to anyone. He ridicules those that are less musically talented and keeps playing, even if one of the others or I are talking. He seems to be incapable of integrating his peers into the music. He has to act as the tough, macho guy trying to make his group members laugh. His coping style during this session is to overpower others, to diminish arousal by laughing about others and change his perception of the music therapy situation by becoming sarcastic.

Mister E. plays very hesitantly, but joins in the laughter. He has trouble following the musical patterns and asks about the necessity of music therapy. He accepts my explanation and keeps participating. When he becomes the laughingstock he sits down on his chair and pushes his conga away from him. As soon as he feels that I firmly reject and tackle this bullying, he shares more about his behavior and insights. His coping style during the session has been evasiveness. But in such a way that he attracts a lot of attention. As soon as he feels protected, he tends to seek acceptance and affirmation from the therapist, by expressing feelings and degrading his group members.

Mister R. starts by showing off his musical talent, playing the drum kit. His verbal reactions and musical ones do not match (For example he says: "I played well, on the right instrument", while switching three times to a different one and not joining in the first assignments). He tries to bond with Mister C. by laughing about all his jokes and adding fuel to the flames. His coping style is to show off, to bond with someone who seems to be 'stronger' and to reduce tension by cynical remarks and laughter.

Mister S. starts off saying that he does not want to have anything to do with Mister R. He plays very carefully, is very attentive to what the others do and adjusts to all their changes. However, he forgets to listen to himself. His playing (laughing and speaking) is all very soft, but he is capable of saying what he would like to change so they can play better together. His coping style is adjusting to any other person,

loosing touch with himself. Yet when he gets the attention he is able to speak up, but does not ask for it.

During the following assignments, they work more seriously, but the restlessness and the incapability of disclosing any of their feelings remain. If I link this feeling to craving for a cigarette (or a joint), each of them agrees immediately.

Phase 3 Recognition. The goal of this phase is for the client to recognize personal strategies by elaborate musical coursework. One of the most frequently used tools for both therapists is popular music (e.g. Horesh, 2003).

In phase 1 and 2 the therapists help the clients to set up a coping strategy scheme and formulate their goals and objectives for change and alternatives. The personal coping strategies and style are linked to the clients' daily life and the transfer is made to high risk situations of drug/alcohol abuse.

An example of primary addiction care:

Gary is a 40-year-old man, with a serious drinking problem; he alternates sober periods with extreme alcohol abuse. During his drinking episodes he behaves in an aggressive way, and has caused a lot of problems in his social environment (work, family, friends and neighborhood). When he is drunk he seems to express that he is "mad at the world".

During the music therapy he is always friendly and cooperative. He always follows the initiatives of other clients. He applies himself to whatever someone else wants, even if he has ideas of his own.

In his point of view he has no social problem at all. While playing the music (assignment 5 and 7) he follows and conforms to all the dynamic patterns of other group members. He starts to develop his own initiatives but when someone else prompts another idea Gary conforms again. During the verbal exchange, he does not recognize, nor is he aware of this behavior. During this exercise his interaction structure seems to be limited to attuning, while his coping strategies are limited to denial and evasiveness.

In phase 2, in the course of his solo there were two other clients playing terribly loud and they were not aware of Gary's efforts to sound his solo. The other group members were very irritated by the loud playing of these two. After the improvisation, Gary said, that he didn't hear it and it didn't disturb his playing and if it did, it didn't matter. He seems to be unable to really register what is going on and partly seems to be in denial. The video of this improvisation shows the interaction structures of Gary: playing, attuning, taking-turns and exchanging. Only when his exchange turn is not confirmed by the two others, his body freezes more and more and the intensity of his musical performance fades. The more he freezes his movement and playing, the more tension is visible in his mimics. The group interpreted

this facial expression as angry. He makes the transfer to his personal coping style: Due to the fact that he denies, ignores and trivializes his surroundings, he builds up a lot of stress and tension and feels frustrated about everything. He recognizes this kind of undefined tension. He labels this as high risk situations, maintaining his drinking habit. This is his coping strategy to reduce arousal. While drunk, he is able to feel and express his anger about everything. Gary chooses to learn to express himself and be aware of his own feelings. He chooses to use his voice and work on the song “sorry seems to be the hardest word” by Elton John and Timothy Rice.

Phase 4 *Experimenting with new strategies.* The objective of this fourth phase is to learn new coping strategies, how to handle and when to use them.

Bring about new (coping) strategies by vocal exercises. Both therapists use a lot of popular music such as rap and popsongs.

After the client has chosen his own goals, what he wants to learn in this phase, he is guided to choose his own musical tools to achieve for these changes. The client is encouraged to use his voice, to learn to express himself in a more personal way.

In primary addiction care this phase is kept in a group setting, so a client chooses the way he wants to get support from the other group members. He can choose to do it alone, together, parts together, etc. In forensic treatment this fourth phase is done on an individual basis, due to social and empathetic impairments of the clients.

This is a text example of a client in the forensic setting who suffers from poly-drug-dependence. He rapped to a beat of one of his former gang-members, using his own text. The first text he wrote *during phase 2* of his music therapy treatment. It focusses on violence and drugs²:

This is the first time I'm writing on command
What you gonna be and where you gonna stand
Three weeks ago I was going in smooth
Smoking my joints, that's the whole damn truth
I don't give a shit if you really don't know me
But wait... I will come and I will show you

2. Thanks to N.V.d.V. for allowing us to use his text.

(...)

What do you want every day again?

Fuck you with your gate and better be straight

The three weeks are flying. I was forced to therapy

Do you really want to know, who I really want to be?

Ha, ha, that's a goddamn question

I know the answer, but never will I mention

What's going through my mind.

During phase 4 he rewrote the text as:

When I wake up it's every day the same,

Put the music on, it's nothing but a game.

How do you feel about music everyday?

It really doesn't matter if you're straight or if you're gay

Every week I'm waiting for the music therapy

That's how it is, to make my pain free.

My soul, my pain, it's all in order

When I hiss scandal, it's nothing but disorder

"Three strikes you're out", it really doesn't matter,

I really have to laugh; I really know what's better

Critical decisions gonna pull me through,

Thanks for supporting; I know now what to do.

FIGURE 3. Working with lyrics (Participants of a workshop at the EMTC conference in Finland)



Phase 5 Termination and evaluation . The goal of this last phase is to help the client to acknowledge his new coping strategies and to recognize how and when to use them in a transfer to his daily life. Of course this phase is meant as the round-off, with all the persistent rituals.

An example of a 32-year-old woman, who recently finished her treatment in an addiction clinic: Music therapy was one of Lisa's therapies during her 5 months of treatment.

During the first phase of music therapy she was often composed. When she talked you could barely hear her voice; group members often had to ask to repeat herself more loudly. When she played, she did not make loud noises or sounds and she never played exceptional patterns. At the same time she had a strong desire to make music; she enjoyed playing together with the other clients and making up rhythmic patterns. While 'moving together' with the others she felt safe enough to play. As soon as the more individual assignments were introduced such as playing solo as described in phase 2 part 5), she hesitated. The moment she played her solo she neither played different patterns nor did her volume rise above the volume of the others. Her body-language showed less movement and she stared more and more at the floor, she lost the potential to 'take turns' and exchange with the other group members, her body seemed to "freeze". During the verbal analyses of that experience, she disapproved of her struggle to play and spoke about herself in negative words. She felt sad and trapped in her own body.

After this experience we started to make a transfer to her daily life. In her daily life she felt isolated, although she had friends and a social system, she often felt stupid and stiff in contact with others. She had difficulties sharing her insecure feelings with other people. Making contact with others was like playing the solo; she felt insecure and started to freeze without sharing any of these feelings.

Drugs, party-drugs (XTC), cocaine and alcohol helped her to feel free and open, to integrate into the groups she wanted to belong to, and to make contact with others more easily. Abuse for her was the way to cope with low self-esteem and introvert conduct.

The goals she set for herself in music therapy, were: higher self-respect, accepting and learning to handle her introvert part, sharing problems, doubts and worries with other people.

She was ready to start with phase 4, experimenting with new strategies. Liza decided to use her voice as her main instrument during music therapy treatment. It was the result from the beginning; she wanted to change the fact that she never spoke loudly. She chose her favorite song "Don't know why" from Norah Jones and experimentally worked on it step by step. During this phase the therapist and group members coached her about how to move her body and how to use her voice. She started to sing the song together with all other clients. The next step was to sing it with two others, followed by small parts of solo voice. And finally she sang her favorite song alone with a microphone using the group members as her audience. Although she kept her moments of 'freezing' she learned to accept that this was a part of herself and she learned to accept how to handle this part of herself.

During the last phase of music therapy she rounded off her music therapy group sessions. The last time she was there she chose to play a drumming solo while the others kept the beat steady. This time she still played a little bit insecure, but very loud.

Three months after finishing the group sessions she had a serious relapse, expecting she could now use drugs and alcohol in a social way. Instead of hiding, isolating and blaming herself, she decided to ask for professional help and support again. She now comes every 3 weeks for individual music therapy, to practice coping strategies such as making her self heard and dealing with insecurity. In addition she visits a weekly support-group to help her to stay clean.

Discussion and conclusion

Music therapy can help clients suffering from addiction to (re)gain better coping strategies. Music offers a client the possibility to act in a structured, playful, safe environment. A well-trained music therapist is capable of manipulating these situations musically, to provide the right confronting experiences, so the client can obtain insight, and practice with coping styles and strategies. They cannot just talk their way out, but a client has to act to prove that he can deal with different situations in different ways and has more alternatives to choose from than narcotics or alcohol.

The basic principles of the method are: introducing client's own musical preferences, using popular music, using voice and rhythm, combined with the transfer from musical to common behavior with a focus on addiction, coping and body language.

During music therapy treatment, clients are placed in situations that show similarities with their daily life. Yet the musical context makes it distinctively different. This helps a client to reconsider his condition and choices from a distance. It can help him to gain insight in his coping strategies, because it has no direct personal consequences if he falls short. The therapist has to stimulate the client to make transfers of these musical processes and learning experiences to his daily life; especially to promote application of the new coping strategies in situations that might otherwise trigger substance abuse.

There are major differences between the two client groups, because the primary focus of clients in forensic setting is upon their offence and related problems. Addiction is one of the related problems that is addressed, always in relation to the behavior that led up to the offence. The emphasis is placed on elaborating empathetic coping skills and confronting problematic situations. Addiction is viewed as a major risk factor for relapse but has a different place in the bio-psycho-social treatment compared to an addiction clinic.

Although the authors work in different clinical settings and have adjusted the music therapy program to their own needs and experience, they are both excited about this methodology. It offers the therapist a focussed, goal-oriented and musical method to help clients conquer some of their major problems with substance abuse. It influences overt behavior and coping styles, but also offers clients a better insight and understanding of their own actual behavior and reactions. This methodology can be used with a variety of clients with coping problems or rigid coping styles (probably even without addiction problems) as long as they do not suffer from mental limitations.

However, as we stated at the beginning of the article, substance abuse is a very complex problem. Most of the clients will have (major) relapses, especially if the only component of their treatment would be focussed around this topic of enhancing coping strategies. Only in the complete bio-psycho-social treatment might a client develop enough to conquer his addiction. Relapse prevention is very crucial in this treatment, where relapses are very common as well.

It would be interesting to compare and measure the coping skills of clients before and after their music therapy treatment by using the UCL (Utrecht coping list), and to compare musical with non-musical coping strategies. This might even result in a validated music therapy assessment list.

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CHAPTER 17

*Intelligent music systems
in music therapy*

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**Editors note: Check for the html version with all video and audio files on
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Abstract

This paper describes an ongoing research project, the purpose of which is to develop an automatic (computer-based) music analysis system that could be used in the analysis of improvisations produced in clinical music therapy. The paper begins by putting the project in context, and outlining the overall method employed. Following this is a description of some of the analysis tools developed so far, after which some examples are given of how these tools might be used in the clinical setting. A small pilot study, the aim of which was to examine the appropriateness of part of the overall method, is then outlined. The paper concludes by describing some of the details of the project, particularly how the clinical data is gathered, and what is required of the therapists who have agreed to participate in the project.

Background

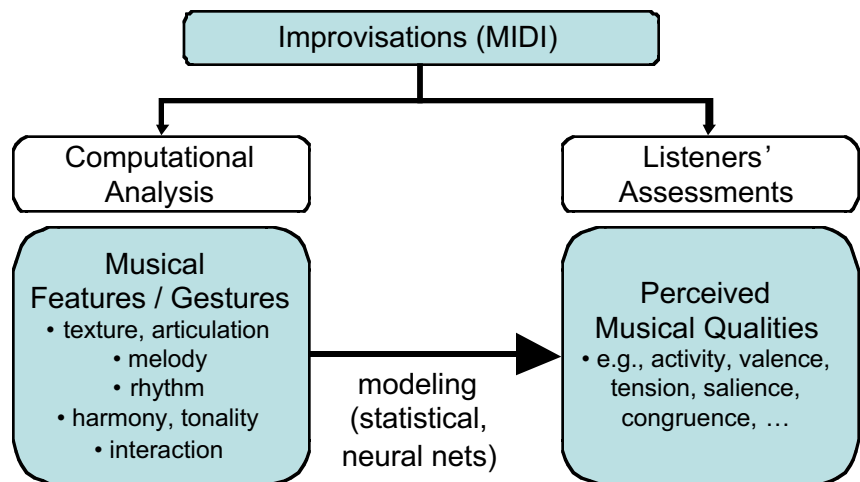
Intelligent Music Systems in Music Therapy is a three-year (2003-2006) research project funded by the Academy of Finland. The objective of the project is to develop automatic music analysis systems that can be used, among others, in analyzing improvisations produced in clinical music therapy. The development of the analysis methods is based on the research work carried out during the last ten years by the Music Cognition Group at the university of Jyväskylä (www.jyu.fi/musica/cognition). This work focuses on the perception of melody, rhythm, and tonality as well as improvisation, variation, cross-cultural music cognition, and computational music analysis.

We suppose that suitably chosen features extracted from a musical performance (e.g. clinical improvisation) can be used to predict assessments given, and thus psychic meanings attained, by therapists. Furthermore, we assume that these methods could be developed into computational analysis tools that would help make clinical music therapy work more effective. Finally, we suppose that interactive music systems based on intelligent musical feature extraction would be more rewarding and efficient than the present ones from the point of view of music therapy clients.

To carry out automatic extraction of musical features, current knowledge about musicology, psychoacoustics, and the perception of melody, harmony, rhythm, and tonality will be applied. The methods will be based on statistical analysis as well as various modeling techniques (e.g. neural networks and dynamic systems). The connection between the extracted musical features and the perceived qualities of

improvisations will be studied using listening tests. To this end, a set of improvisations will be subjected to automatic feature extraction to obtain descriptions of musical features and gestures for each improvisation. For the same improvisations, experienced music therapists and musicologists will provide subjective evaluations of given perceived qualities. The interrelationship between the musical features and the perceived qualities will be investigated using various statistical and modeling techniques. We seek to obtain models that, given the extracted musical features, provide estimates of perceived musical qualities. To this end, various statistical and neural network methods will be utilized. Figure 1 on page 926 shows a schematic overview of the methods used.

FIGURE 1. A schematic representation of the method for obtaining a system for automated analysis of improvisations.



Analysis tools

The computational analysis is based on the MATLAB software (www.math-works.com). MATLAB is a programming environment for mathematical computa-

tion, analysis, algorithm development, and visualization. Depending on the application area, the MATLAB software can be supplemented with various *toolboxes* that contain specialized functions (e.g., signal processing, neural networks, statistics, fuzzy logic). Currently, the analysis is carried out from MIDI files. To access and analyze them, we use the Midi Toolbox (Eerola & Toivainen, 2004). The MIDI Toolbox is a compilation of functions for analyzing and visualizing MIDI files in the MATLAB environment. Besides simple manipulation and filtering functions, the toolbox contains cognitively inspired analytic techniques that are suitable for context-dependent musical analysis that deal with such topics as melodic contour, similarity, key-finding, meter-finding, and segmentation.

The analysis methods used specifically for music therapy improvisations are compiled into another MATLAB toolbox, the Music Therapy Toolbox (MTTB). The MTTB utilizes various functions of the MIDI Toolbox (see Figure 2 on page 928). Currently, the MTTB provides graphical representations of certain musical features of the improvisation. These features are related to:

- density of notes
- dynamics of playing
- usage of register (pitch height)
- duration of notes
- clarity of pulse and tonality

When there are two improvisers, these features can be separately displayed for each improviser, allowing for the examination of interaction between the improvisers on these musical dimensions.

The MTTB is continually developed and extended, using feedback received from clinicians and music therapy researchers involved in the project. As an end product, we aim to develop an improvisation analysis software package for music therapists.

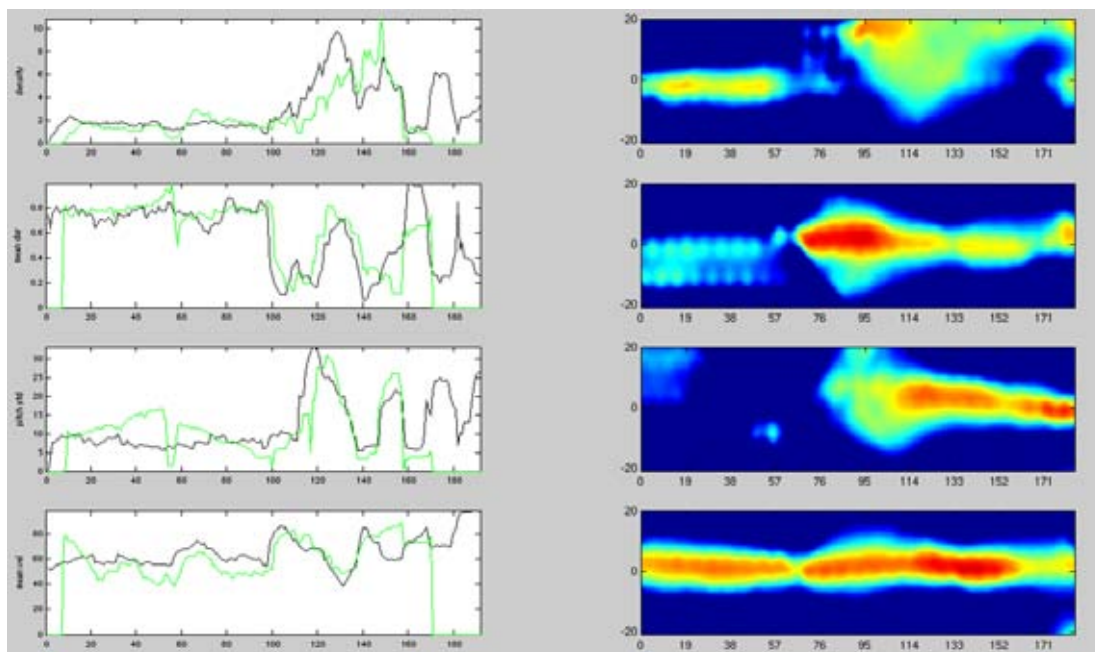
FIGURE 2. Hierarchy of the analysis tools used



Evaluation and representation of musical dialog between therapist and client

One important dimension of musical expression that may be of interest for music therapy is the degree of communication between the therapist and the client playing together. In particular, when communication takes place, players imitate one another at some particular moments of the improvisation. The assessment of musical dialog may therefore be assessed through an observation of the degree of local similarity between the temporal evolutions of both improvisations, along the different features computed by the MTTB (density of notes, dynamics of playing, etc.). These local imitations are displayed in a new graphical representation – called *imitation diagram* (ID) – that has been specially designed for this purpose.

FIGURE 3. Temporal evolution of the musical variables (on the left) and their respective imitation diagrams (on the right).



- download and listen to mp3 (3 MB)
- download the MIDI file (12 kb)

Each line of Figure 3 on page 929 is dedicated to a different musical feature: note density, mean duration, pitch standard deviation, and mean velocity. On the left side the temporal evolution of the corresponding feature is displayed with respect to each player, player 1 in black and player 2 in green. On the right side the respective ID is associated, where the horizontal axis also corresponds to the temporal evolution of the improvisation. Lines in the ID indicate local imitations. Color of lines is associated with strength of imitation: blue corresponds to slight and coarse similarities, while yellow and, to an even greater extent, red, correspond to distinct and close imitations. When the line is vertically centered, the imitation between both players is synchronous. When the line is at the upper side of the diagram, on the other hand, player 2 imitates player 1 after a specific delay, displayed by the vertical axis, in seconds. Similarly, when the line is at the lower side of the diagram, player 1 imitates player 2. Finally, the length of the line indicates the duration of the imitation.

This representation displays some interesting information. With reference to note density (first line), player 2 imitates player 1 from time 100 seconds, with a delay of 20 seconds. As regards mean duration (second line), player 2 imitates player 1 from time 70, with a slight delay of a couple of seconds, and player 2 becomes ahead at time 115. Meanwhile, with reference to pitch standard deviation (third line), player 2 imitates player 1 from time 115, and both players become progressively synchronous. Finally, as regards mean velocity (fourth line), both players imitate each other during the whole improvisation, one player being ahead at some points, and the other player at other points. All these characteristics can be seen in the graphs on the left hand side.

Music Therapy Toolbox from a clinical point of view

We aim to test the Music Therapy Toolbox (MTTB) in real clinical contexts. Thus, we have established a network (which will be described in detail later in this article) where music therapists who are working in institutions for handicapped people will participate in the project by providing data as well as by giving feedback for the researchers – for instance suggestions for improvements and usefulness of the method. We hope to get the network ready and to receive data from the field from Fall 2004. In the pilot stage we have tested the method mainly with music therapy students – a setting which deviates somewhat from that in institutions for handicapped people. Nonetheless, the pilot setting will help evaluate the clinical relevance of the analysis method.

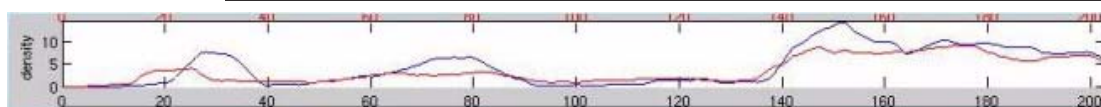
The improvisation discussed next was created by two students. It was created without any givens, instruction or predestined roles. This way, the starting point was up to them, and as free as possible. Due to the specific requirements of the analysis method, the students could not choose the instruments – two identical midi-pianos – by themselves.

After completing the improvisation, which was recorded on the hard disk of a PC, the students were asked to listen to it again as playback, and to verbalize their images, which were also recorded on the hard disk. The students performed the verbalization task separately so that they would not be influenced by what each other said. The students did the imagery trips separately without hearing each others' images until they both had finished the session.

MUSICAL DENSITY IN FREE IMPROVISATION

In figure 4, the trend lines of musical density are depicted so that the red line represents improviser 1, the blue line improviser 2. The numbers below the trend lines indicate the duration of the improvisation in seconds. The density is simply the average number of notes played in a given time window. We can see that there is a clear increase of density starting after approximately 140 seconds, and lasting throughout the rest of the improvisation.

FIGURE 4. Musical density depicted as a MTTB graph

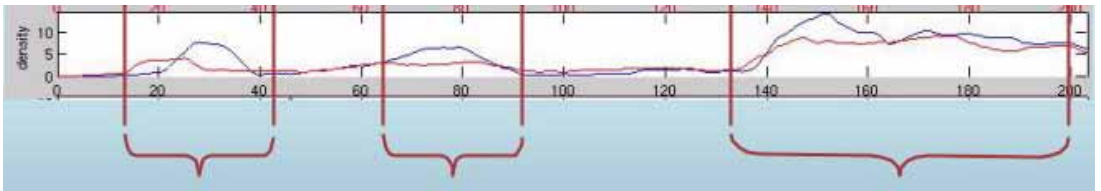


The concept of density in MTTB can be compared with the concepts of activity and arousal that are well known concepts in (music) psychology. After McMullen (1996), activation has often been explained as an increased state of arousal, and activation is frequently used even as a synonym for arousal. McMullen also refers to the work of Osgood, Suci and Tannenbaum, who have stated that, when depicting connotative meaning, one of the key factors is the activity dimension.

Increased density in improvisation seems to consist of the contribution of several musical factors, including increase in volume, acceleration of tempo, shortened note durations, and increased number of notes in a given time window. When this kind of overall increase – arousal – in musical expression occurs it is a sign of increased emotional and physiological intensity as well (Husain, Thompson, & Schellenberg, 2002).

If the theory suggested above has any clinical relevance, music therapists should be able to utilize musical density in many ways. Because of the importance of arousal and activity in music, and because density seems to be a close relative to them, any changes in density should have clinical relevance. We might, for instance, use the changes in density in order to divide the improvisation into sections, like in figure 4.

FIGURE 5. Utilizing musical density in dividing improvisation into parts

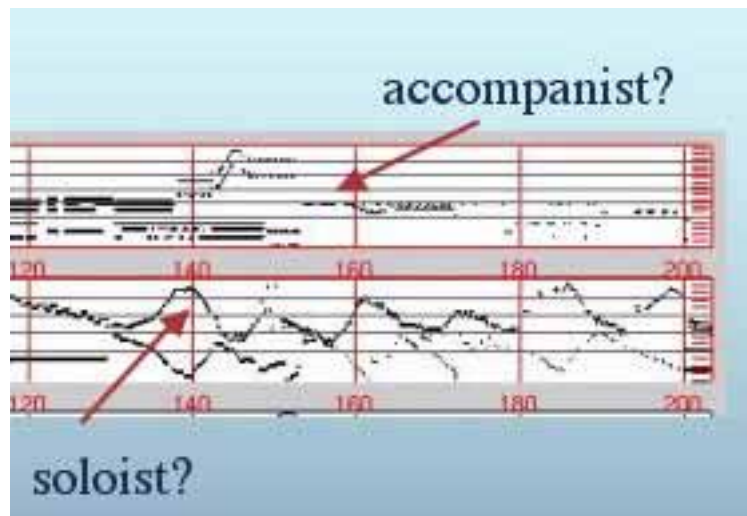


There are three parts with increased density, of which the last and longest one seems to be most intensive for both of the improvisers. When comparing the imagery processes with certain parts of the improvisation it became clear that the intensity of images was higher in the part with increased musical density (from 140 sec onward).

MELODY TOGETHER WITH ‘VOLUME’

When looking very carefully at the trend lines of the improvisers from 140 sec onward, where the density starts to increase, one can see that Blue’s music seems to be more dense, especially during the first 20 seconds. Let’s see what the melodic expression of the improvisers looks like within the same part (figure 6).

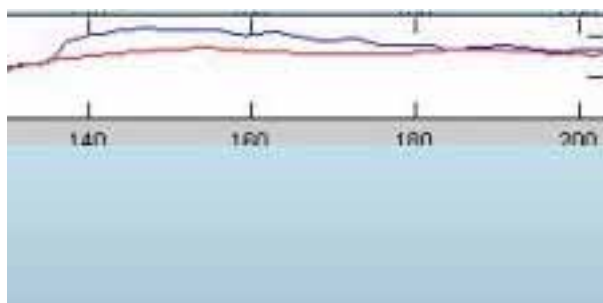
FIGURE 6. Piano roll representation of the part with high density. Blue = lower stave, Red = higher stave.



It seems that 'Blue' is very expressive. 'Blue' is using both hands, and producing melodic contra-movements with the right hand dominating. In the beginning, Red also makes an attempt to produce melodic contours – influenced by Blue who set the new course of improvisation around 140 sec. It seems that Red gives up the expressive role, and is satisfied with her role as accompanist to Blue.

It is possible to confirm the assumption about Blue's stronger expression by looking at the velocity graph (Figure 7). Velocity is a MIDI-concept which can be associated with volume in musical vocabulary – with reservations. After Bruscia (1987), volume in music contributes to the emotions by indicating how much energy is directed towards the object, and how intense the emotion of the object is. Volume symbolizes power, force, strength, size and commitment. In this sense, the difference in volume between the improvisers – when Blue seems to use more volume – is in harmony with the other sources that form the basis for the interpretations.

FIGURE 7. Velocity graph of the part with high density



After Mélen & Wachsmann (Mélen & Wachsmann, 2001), infants of only 5 months are able to perform musical discrimination on the basis of melodic contours. So, the question must be about a very characteristic (important?) feature of music. Interestingly, in psychoanalytically orientated music therapy, only melody has been defined to be a specific expression of emotion (see Bruscia 1987). Can we then conclude that Blue's role in this particular part is more emotional and more expressive? In order to answer this it might be interesting to have a look at the images at this point of improvisation (around 140s.):

BLUE: "Oh yes!", "Freedom and action!", "No signs of anxiety!" etc. [speaks loud and with dynamic manner]

RED: "The wind...it is too hard", "I don't like this", "Why doesn't it stop?" etc. [speaks softly without as much dynamics or volume]

There seem to be clear similarities between the musical and verbal roles of the improvisers. What was possible to conclude on the basis of the graphs seemed to be in harmony with the reports by the improvisers. In addition, the interpretations derived from the analysis brought out many details of the interaction between the improvisers, as well as psychic processes that would have remained at the pre-conscious level without the analysis process and the consequent interpretation: “from signs to symbols, from symbols to words”.

A Pilot Study – Human experience versus computational feature extraction

INTRODUCTION

This section describes a small pilot study, the purpose of which was to assist in the development of the part of the project in which experienced music therapists and musicologists would subjectively evaluate clients’ improvisations (see “Background” on page 925).

In the pilot study, music therapy students were required to give subjective ratings of a series of short (60 sec) improvisation excerpts. Each excerpt had to be rated on two scales: perceived ACTIVITY, and perceived VALENCE. These two scales were selected on the basis of a number of theoretical accounts which suggest that relationships between musical stimuli and affective/aesthetic behaviour can be predicted using a two-dimensional – activation/activity, and acceptance-rejection/evaluation – framework (McMullen, 1996).

With regard to the second of these dimensions, the concept of valence, based upon pleasant-unpleasant judgments usually investigated using several adjective pairs, is frequently used to describe affective/aesthetic responses to musical stimuli (Rauhala, 1973). Thus, activity and valence may be seen as central agents in the process in which one is judging the psychological meaning of musical stimuli, or the differences between stimuli.

The subjective ratings obtained in this experiment were to be compared with the musical features extracted from the excerpts using the computational methods described in the previous section. Using regression analyses, it was anticipated that some of the extracted musical features would be good predictors of participants’ activity and valence ratings.

METHOD

Participants. Thirteen individuals participated in the pilot study. All participants were students on the Master's music therapy programme at the University of Jyväskylä.

Stimuli. Participants were presented with twenty 60-sec excerpts from therapist-client improvisations produced by students on the Master's music therapy programme in the department of music at the University of Jyväskylä. The improvisations were produced during a typical student training session. The excerpts were selected from thirty originally recorded excerpts, each of which were 2 – 4 minutes in length.

Apparatus. An Apple Macintosh computer, running Logic sequencing software, was used to present stimuli to participants via headphones. Attached to the computer was a basic four-octave keyboard equipped with a data entry slider and a pitch bend wheel. Participants used the data entry slider to indicate the level of perceived ACTIVITY, and the pitch-bend wheel to indicate perceived VALENCE.

Procedure. Participants were presented with the twenty excerpts in two identical blocks. The start and end of each excerpt was signalled by a percussive tone, and there was a period of six seconds of silence between each excerpt and the next. During the first block, participants were required to rate the amount of perceived ACTIVITY. During the second block, they were asked to rate perceived VALENCE. During both blocks participants' ratings were sampled at 500 ms intervals.

RESULTS

Using the computational methods described in the previous section, the following musical features were extracted from each excerpt, with a 3-sec sliding window moving at 500 ms intervals:

TABLE 1. Abbreviations

| | |
|-------|---------------------------------------|
| DENS | note density (note onsets per second) |
| DUR | mean durational accent of notes |
| MEANP | mean pitch (MIDI note value) |
| MINP | minimum pitch |
| MAXP | maximum pitch |
| STD P | std of pitch values |

TABLE 1. Abbreviations

| | |
|-------|---------------------------------------|
| DENS | note density (note onsets per second) |
| MEANV | mean velocity |
| MINV | minimum velocity |
| MAXV | maximum velocity |
| STDV | std of velocity values |
| TON | tonal clarity |
| MAJOR | clarity of major key |
| MINOR | clarity of minor key |
| ART | articulation index |
| AC | pulse clarity |

Ratings of ACTIVITY and VALENCE were analyzed separately. For each dimension, the values of the 15 extracted musical features, and the mean rating made by participants, were used as predictor variables in a linear regression analysis. Significant models emerged from each analysis, and are shown in Table 2 on page 936 (ACTIVITY) and Table 3 on page 937 (VALENCE) below.

TABLE 2. Results of regression analysis for ACTIVITY. Using the *simultaneous* method of variable entry, a significant model emerged [$F(15, 2384) = 196.462, p < .001$; adjusted R square = .553]. Significant variables are shown below.

| Predictor Variable | Beta | Significance Level |
|--------------------|-------|--------------------|
| DENS | .542 | $P < .001$ |
| MEANV | .248 | $P < .005$ |
| MINP | .229 | $P < .005$ |
| MEANP | .191 | $P < .05$ |
| MAXV | .177 | $P < .05$ |
| AC | -.146 | $P < .001$ |
| MINV | -.130 | $P < .05$ |
| STDP | -.128 | $P < .05$ |
| TON | -.127 | $P < .005$ |
| DUR | .100 | $P < .001$ |
| MINOR | .085 | $P < .005$ |

TABLE 3. Results of regression analysis for VALENCE. Using the *simultaneous* method of variable entry, a significant model emerged [$F(15, 2384) = 24.403, p < .001$; adjusted R square = .128]. Significant variables are shown below.

| Predictor Variable | Beta | Significance Level |
|--------------------|-------|--------------------|
| MAXV | -.613 | $P < .001$ |
| MAXP | .533 | $P < .001$ |
| MINP | -.507 | $P < .001$ |
| STDP | -.491 | $P < .001$ |
| MINV | .326 | $P < .001$ |
| STDV | .254 | $P < .001$ |
| TON | .108 | $P < .05$ |
| ART | -.061 | $P < .05$ |
| AC | -.051 | $P < .05$ |

Summary

A number of the computationally extracted variables were found to predict participants' ratings of ACTIVITY and VALENCE fairly accurately. The most significant of these variables were DENS (note density), MEANV (mean velocity), and MINP (minimum pitch).

Overall, this study suggests that there is some connection between the extracted musical features and the perceived qualities of the improvisations. Subsequent experiments, which will build upon the pilot study presented here, will attempt to describe this relationship in more detail.

Clinical applications of the Music Therapy Toolbox in the project

Clinical use of the Music Therapy Toolbox is currently at a test stage. After the very first trials with music therapy students there is a need to explore the possibility to apply the Music Therapy Toolbox in various clinical settings. A decision was made to begin this work at institutions for intellectually disabled. In Finland there are a total of 17 districts of services for intellectually disabled / federations of municipalities, and in addition to these there is the Rinnekoti-Foundation that provides residential and rehabilitation services on a large scale. At 7 of these 18 institutions, one or more qualified music therapists are available. 4 of these 7 institutions accepted the opportunity of contributing to this research project. These open-minded forerunners, who have also given human and material resources to be used in this project are: Pääjärvi Federation of Municipalities, Rinnekoti-Foundation, Satakunta District of Services for Intellectually Disabled, and Suojarinne Federation of Municipalities.

Qualified music therapists who are contributing to this research project are: Arto Mäkelä (Satakunta District of Services for Intellectually Disabled), Kimmo Pyhälä (Pääjärvi Federation of Municipalities), Heikki Raine (Rinnekoti-Foundation), Leila Varkila (Pääjärvi Federation of Municipalities), and Jukka Värri (Suojarinne Federation of Municipalities).

Music therapy clients in contributing institutions are mostly mentally retarded but there are other clients as well. This situation results from the development of open welfare over the years: many residents of large institutions have moved to small units or to some other more independent residence. As the services of institutions are still available many other directions have noted this situation and asked for residential and rehabilitation services, including music therapy. At this time, when 10 clients have contributed to the present research, only about half of them are diagnosed as mentally retarded, while others have some psychiatric diagnosis or other neurological diagnosis than mental retardation. Mentally retarded clients have mostly a mild disability. However, it is too early to make predictions about diagnosis distribution of clients to come.

Research data is gathered from clinical situations. A music therapy session includes improvisation, during which client and therapist play together with two separate but identical MIDI keyboards using piano sound. Length and content of improvisation is not restricted. MIDI controller keyboards, with no built-in sound, but 88 dynamic keys with full hammer action and aftertouch are used. The piano sound

comes from a sound module. Improvisations are recorded with sequencer software. The MIDI files produced are then sent to the researchers via the web. This combination is rather complicated and sensitive to accidental changes. Many technical problems of poor quality and incompatibility between components have been encountered. In spite of these problems, data collection has begun.

In addition to improvisations, therapists explore clients by performing a test called the MIDI test, in which the therapist models some basic motor functioning on the client's keyboard, and the client tries to repeat what the therapist has played, or what the therapist has asked the client to play. The purpose of this test is to find out how well the client can use his or her hands and fingers, as well as mapping some simple musical skills. The MIDI test does not require concentrating on papers in the test situation because the information will be saved as a MIDI file that can be analyzed later.

Moreover, the therapists are required to fill in web-based forms. An improvisation assessment form must be completed after every improvisation. It is a checklist that includes some musical as well as nonmusical assessment in a subjective manner. It also contains a free field for the therapist's and client's comments on the current improvisation. A basic information form is completed after the very first improvisation session only. This form contains questions concerning the client's age, diagnosis, and verbal as well as motor functioning.

Every third month, therapists have to complete a follow-up form, which is the same as the basic information form. Although some of the information the therapist provides on this form may change over time, diagnostic information usually remains the same over longer periods.

MTTB analysis is then performed to investigate possible connections between motor, mental, emotional, or social functioning of the clients, and musical features of the improvisations. Gabrielsson & Lindström (2001) have summarized research results concerning relationships between musical features and emotional expression, and Juslin (2001) has examined emotional communication in music performance as a function of musical codes placed on dimensions of valence and activity. Their work is a well-established basis for analyzing emotional content of musical features in music therapy improvisations.

Motor functioning is present in all MIDI data. Note clusters, for example, may suggest limited motor skills. As dissonance, they can be interpreted as emotional expression as well. To avoid incorrect interpretations, reliance upon only on one musical feature may not be enough in all cases. Some clients are probably able to

express themselves by using major/minor tonality that can be also treated as an element of emotional content of an improvisation. In addition to motor and emotional functioning, MTTB analysis is expected to reveal something about the social functioning of the client. In an MTTB graph it is easy to see the level of synchronization between the musical functioning of client and therapist. Initiative actions, and following responses, can easily be detected as well.

MTTB analysis may or may not reveal some common features between clinical subgroups, or between some other classes investigated, but before obtaining and analyzing more improvisations it is too early to make extensive generalizations about this subject.

Conclusions

The aim of this project is to develop computational improvisation analysis tools for music therapists to use in everyday clinical practice. While therapists may choose to base much of their analysis on non-computational techniques, it is anticipated that these tools will help illuminate the musical interaction and experience shared by the client and the therapist. The process of turning an auditory input, i.e., a client-therapist improvisation, into a visual output, such a representation of client-therapist interaction, results in a static representation of a temporal event. When utilizing computers in this way, we can be sure that the visual representation is at least precise. What we cannot say yet, however, is whether the features we represent are clinically relevant. The relevance of the extracted features should become more apparent as the project unfolds.

The next stage of the project, to be carried out in collaboration with clinicians, is to test and develop the method with improvisational data gathered from the field. If the MTTB is found to be appropriate in the clinical setting with this particular group of intellectually disabled clients, it is hoped that the method could be applied to other client populations as well.

Acknowledgment.

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CHAPTER 18

*Music and altered states of
consciousness (ASC), sound and
trance in a ritualistic setting*

*visualised with EEG
Brainmapping*

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Background

Work with trance-inducing sounds has become an intrinsic part of receptive music therapy in practice. Therapeutically intended altered states of consciousness enable an intensification of intrinsic perception, a weakening of psychic barriers of everyday-life consciousness a more open association and imagination.

When you go back to the early 70's pages of the 'Journal of Music Therapy' you might find articles by Charles T. Eagle (1972) or Helen Bonny (1972) on the use of altered states, sometimes even induced by psychedelic drugs in music therapy.

One research project published in the German area of music therapy done by Weber (1974) in the 60's focussed on the use of psilocybin, a fungus with psychoactive ingredients. His work was in the tradition of model psychosis research. The aims of this approach are to describe pathological states like the productive states of schizophrenia, which seem to be analogous to some experiences made during psychedelic drug action. In Weber's research a drug-induced altered music perception should serve as a model of functional regression to lower levels of cognitive development.

In certain psychotherapeutic approaches an attempt is made to stimulate and evoke unconscious material for psychoanalysis. Psychedelic research studies used music and fantasy themes as support and guidance in the psychedelic setting (Grof 1975; Leary 1990; Leuner and Richards 1984; Melechi 1997). The beginnings of "Guided Imagery in music" were based on a setting aspect of psychedelic therapy. Certain pieces of mostly classical or jazz music were conducted in a thematic therapeutic order to facilitate emotions, evoke uncensored responses and associations, to open a path to the inner world of the client's unconscious. All this happened in a relaxed

secure and guided setting of psychedelic therapy. Anti-toxicants for a possible bad trip were at hand and therefore the patient could let go (Bonny and Pahnke 1972).

At the beginning of the eighties, some experienced music therapists in Germany perceived a growing interest in the effects of music from outside Europe and started experimenting with trance-inducing effects of monochromatic sounds of monochord, gong, dijeridoo, sound bowls etc., developing individual empirical concepts (Bossinger and Hess 1993; Hess and Rittner 1996a; Oelmann 1993; Strobel 1988; Strobel 1994; Timmermann 1983; Timmermann 1996). These first approaches were revised, further developed and also reviewed critically (Hartogh 2001; Hess 1999; Jungaberle 2003; Zeuch 1999). Although the brain plays a decisive role in the experience of trance states, there is an astonishing lack of music therapy research into psychophysiological aspects of sound-induced trance.

I'd like to present an excerpt from an analysis of two trance inductions, i.e. one in recumbent position on a resounding body monochord (Rittner 1997) and one "ritual body posture" according to Felicitas Goodman (1989; 1992) accompanied by fast rattling sounds.

EEG

The electroencephalogram (EEG), discovered by Berger in 1929, has lost nothing of its fascination (Berger 1991). Positron emissions tomography (PET), functional magnet resonance tomography (fMRT) and other procedures produce highly soluble images of the living brain; but the EEG with its temporal exactness is an ideal instrument to measure electrical processes in the brain, and for music in particular. In addition, an EEG brainmapper provides something like a map of current intensities and wave speeds. Topographical presentations of main frequency ranges permit conclusions on functional interactions of brain regions and their levels of activity (Maurer 1989). Slow and large high-amplitude waves (Delta and Theta) e.g. are predominant in sleep, while in states of high concentration and alertness the waves tend to be quick with small amplitudes (Beta). Depending on vigilance and activity, there are various combinations of different waves. The alpha-frequency band (8-12 Hz), the waves of which emerge when closing one's eyes, acts as a mediator and indicator between the high and low frequencies of the EEG and the vigilant states between waking and sleeping (Basar, Schürmann, BasarEroglu et al. 1997; Schwendtner-Berlin, Berlin, David et al. 1995).

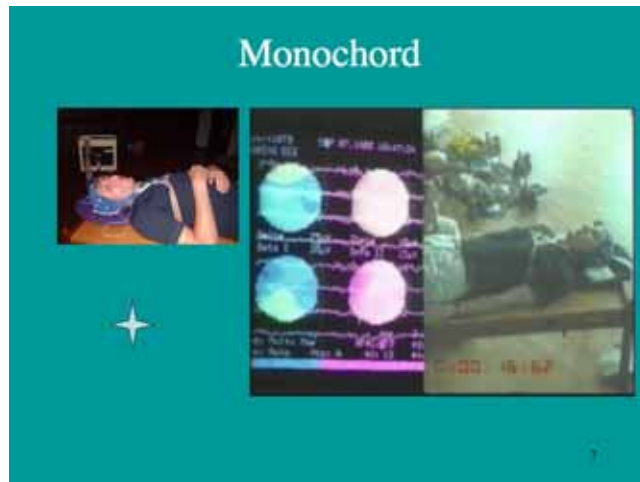
The EEG is a physical indicator of psycho-physiological events. Both dimensions, the emotional experience and the pertinent alterations in the EEG, occur simultaneously and may be correlated to each other, but they do not permit a deterministic assumption of cause and effect.

“The problem is that the experience and its phenomenal and phenomenological, i.e. descriptive expressions are basically different perception modalities which exist besides each other and can never replace nor explain each other. The relation between the perception modalities exists only in their “simultaneity”, i.e. their same temporal coordination” (Machleidt, Gutjahr, and Mügge 1989: 8).

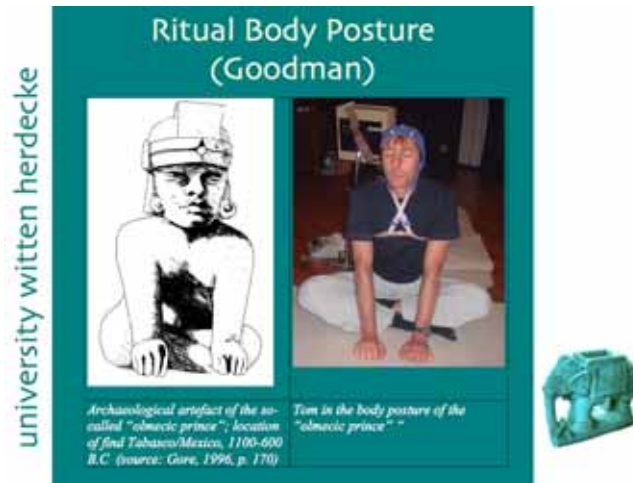
There is a fund of studies available in psychophysiology that may be used for comparison with the research question to come to a better understanding of the complex, psychophysiological interactions involved.

MONOCHORD

FIGURE 1.



The body monochord is based on the design of the monochord invented about 15 years ago as a musical instrument for therapy purposes. It has the form of a double-walled wooden stretcher, with 26 strings of equal length and exactly the same tuning on the underside, so that a person lying on the instrument with eyes closed may perceive sound with the entire body, via skin, bones, vibration of body liquids, and auditory sense. Based on the keynote a, various “sound clouds” with overtones may be produced depending on the type of the music-making. We assume that readers are acquainted with this instrument.

BODY POSTURES**FIGURE 2.**

Primarily, the method of “ritual body posture and ecstatic trance”[®] is not so much a music therapy procedure but rather an approach from anthroposophical research providing access to altered states of alertness, where sound is used as an essential element of trance induction. An integration of this method into the clinical practice of music therapy and psychotherapy has turned out to be highly successful.

A common factor of “ritual body postures” as they are called by the anthropologist Felicitas Goodman – they are up to 32.000 years old – is that as a rule they are perceived as a considerable effort and in combination with the sounds of a rattle or (frame drum) of approximately 210 bpm (beats per minute) produce a spontaneous burst of energy in the body; this burst of energy allows to induce in the subject a controllable hallucinatory experience on all levels of perception (vision, auditory sense etc.).

The members of the group assumed a specific sitting body posture to which they were not accustomed; Goodman studied this posture entitled “olmecic prince” (Goodman 1989: 158-161; Gore 1999: 170-174). This posture was maintained for 15 minutes, accompanied by the rhythmic high-frequency sound of two calabash rattles.

FIGURE 3.



The experience is imbedded in a well-tested, repetitive ritual. The procedure must be exercised so that a subject gets used to and feels safe with an almost unvarying ritual and is thus able to have a visionary experience. We call this a “controlled loss of control”. The accompanying fast and even beat of a rattle has a stirring, although insufficiently researched effect on the central nervous system, due to rhythmic stimulation as well as the extremely high frequency of sound elements in the rattle noises. This combination is assumed to synchronize the naturally rhythmic physiological processes of all participants in the ritual.

No EEG analyses on trance experience on the body monochord were found so far. Studies on EEG and ritual body posture were published by Guttman (1992; 1990; 1992). The term “trance” (from lat. transire, change over to) has been defined in various, sometimes contradictory ways in literature (Meszaros, Szabo, and Csako 2002; Pekala and Kumar 2000; Rouget 1985). We have used it here as a generic term for

“various physical-mental alterations that may occur in persons at changed states of alertness independent of the cultural setting. Stimulus, techniques and ritual that induce and structure a trance depend on the socio-cultural context.” (Hess and Rittner 1996b: 395).

An additional definition of trance by the ethnopsychologist Frigge is

“the disappearance of perception of the surrounding reality – due to psychological causes – under continued alertness” (Frigge 1994: 231).

Available studies on trance and pertinent alterations in the EEG did not focus on music and trance but reviewed individual differences in trance experiences between a variety of mainly verbal trance inductions (De Benedittis and Sironi 1985; Jaffe and Toon 1980; Meszaros et al. 2002; Oohashi, Kawai, Honda et al. 2002; Park, Yagy, Saito et al. 2002; Sabourin, Cutcomb, Crawford et al. 1990). It is interesting to note that more recent studies by Meszaros, Park and Oohashi come closer to the authentic situation, i.e. trance induction in situ, in their experimental design. In 2002, Oohashi succeeded for the first time in recording a naturalistic EEG of a trance during a ceremony in Bali (via EEG telemetry, specifically designed software and electrodes). At the height of the ceremony with loudly resounding bamboo instruments, a subject fell into trance (see Oohashi et al. 2002: 438). An analysis of the trance phase revealed a distinct increase in Theta and Alpha frequencies.

The question whether trance is a temporary state or a specific quality in persons addresses the state-trait discussion in psychology and has not been answered so far (see Meszaros et al. 2002: 500). Most studies assume differences in susceptibility to hypnosis, and subjects were psychometrically differentiated at the beginning. Sabourin e.g. compared 12 persons with high and 12 with low susceptibility to hypnosis respectively. At rest as well as under hypnosis, persons with high susceptibility to hypnosis had higher Theta amplitudes compared to persons with low susceptibility (Sabourin et al. 1990).

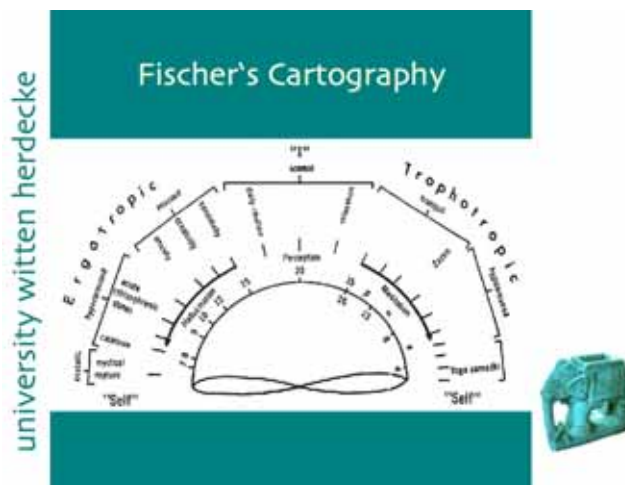
The above-mentioned studies mainly showed alterations on the Theta, Alpha, and also on the Beta band.

Aims

Ergotropic trance (ecstasy) in this context, in the sense of Fischer’s mapping of altered states of alertness (Fischer 1971; Fischer 1976; Fischer 1998), means an alert, non-contemplative, wide-awake state of consciousness. For the purpose of this study we assume that the state or personal ability to experience this state of consciousness may be induced and that the characteristics emerging in the EEG may be differentiated. The degree to which test persons may be hypnotised may be determined by a psychometric instrument (PCI von Pekala 1991a; Pekala 1991b).

“In musical psychotherapy with sound trance, music (...) is effective in two directions: 1. physiologically stirring (ergotropic) towards ecstasy by intensified rhythm in the field of perception (...) or 2. physically calming and internalizing (trophotropic) towards enstasis with reduced field of perception and focussing via monochromatic sounds” (Hess and Rittner 1996b: 401).

FIGURE 4.



Fischer says: “The mapping follows along two continua: the perceptive-hallucinatory continuum of increasing central-nervous (ergotropic) excitement, and the perceptive-meditative continuum of increasing (trophotropic) damping.” (Fischer 1998: 48). “Along the two continua, the sensory/motoric ratio increases. This means: the further you go along one continuum, the less will it be possible to verify the sensory element through random motoricity.” (the same, p. 51)

Accordingly, a trophotropic trance is characterized by a rather relaxed, contemplative, apparently sleepy state, and also by a rather inhibited movement profile, and reduced reaction and willingness to perform (enstasis).

This study compares a presumably trophotropic induction (body monochord) with a presumably ergotropic induction (ritual body posture with rattling) in two test persons. The EEG was expected to show differences of a trophotropic state via EEG synchronization, i.e. via deceleration of the main frequencies and increase of slower wave ranges (Delta, Theta and lower Alpha frequencies of 8-10 Hz) (compare David, Berlin & Klement, 1983). Ergotropic states were expected to show in

an EEG desynchronization and dominance of high-frequency waves (upper Alpha waves, 10-12 Hz, Beta-I, i.e. 12-Hz, and Beta II, 16-30 Hz).

1. Are there intra-individual alterations in the topographical spontaneous EEG compared to undisturbed rest?
2. Which inter-individual differences or common factors may be detected between the two test persons?
3. Does our study reveal an increase in Theta waves in persons highly susceptible to hypnosis?

Methods

Topographical alterations of brain activities in two test persons were measured in a group setting with a topographical quantitative EEG brainmapping. Using pre/post designs, we compared artefact-free means of undisturbed rest (baseline state) with sound trance phases (altered state) induced by the body monochord or the ritual body posture with rattling.

It is a well-known difficulty in physiological measurements that movements or activities in the course of a therapy may interfere with the precision of measurement data. EEG brain-mapping requires a limitation to receptive sound perception with little movement. Ideally, the test persons were to be recumbent or sitting still in order to avoid movement artefacts in measurement results. The NeuroScience BrainImager® used here was designed for EEG on intensive wards where reliable data collection is essential. Galvanic current separation and filter systems permit the recording of a solid EEG signal.

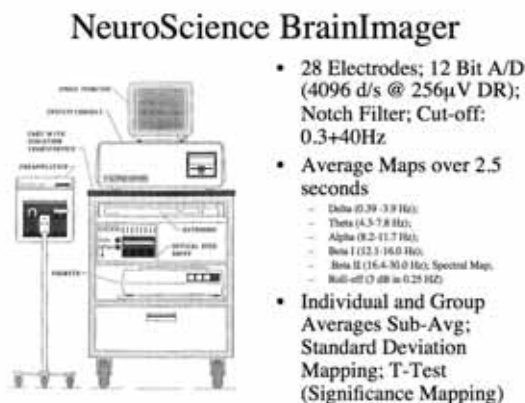
Measurements were taken in a therapy group setting (N=10). We attached specific importance to measurements being made in the ritual setting of a group well known to the test persons with the help of a mobile brain imager. Unlike an isolated laboratory situation, a group setting and familiarity with the experience will ensure that supportive sociophysiological factors influence the sound-induced trance experience for all participants (naturalistic design).

Most attempts to locate practical music therapy in a laboratory setting impair the authenticity of the situation. The documentation of significant moments in therapy on recording appliances in particular demands a sensitive approach. In the realization of such a qualitative electrophysiology study (Fachner 2004) the measuring instruments must be adjusted as far as possible to every-day practice in order to

generate explorative data. Consequently, we collect our data in the immediate therapy situation and not under lab conditions. On the basis of such explorative data collection, a test concept may be designed to review the tendencies revealed in exploration in a laboratory experiment under ideal technical conditions.

For this pilot study we selected volunteers with trance experience who were acquainted with the induction methods. The intention was to ensure a high degree of familiarity with the ritual setting and as little sensitivity as possible to the research situation. We focus mainly on the results for two test persons out of ten participants in total (S. 1: Tom, S. 2: Angelika).

FIGURE 5.



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EEG impedances of the 28 bipolarly (ear and ground electrode) generated EEG traces remain below 15 kohm.

Artefact control is achieved with a video protocol of the TP, the basic EEG data and the definition of a data-specific confidence interval of the respective brain maps. Details may be found in Fachner (2001) and Burgess & Gruzelier (1997). On the Delta band, which is sensitive to eye movements, all those maps were removed that showed Fp1 and Fp1 values in the frontopolar derivations within a dynamic range of above 150 μ V.

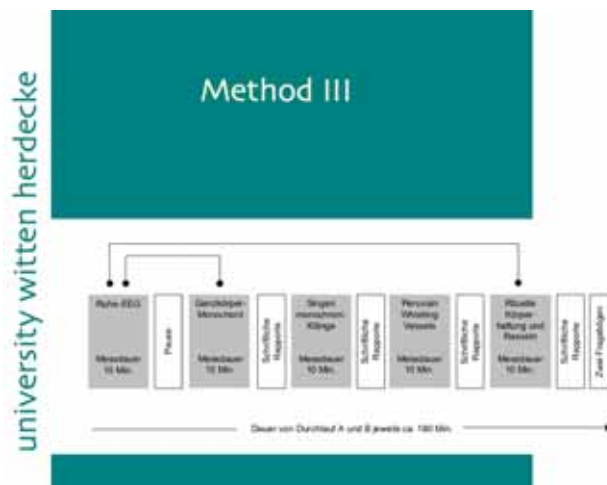
AMPLITUDE MAPPING

Every 2,5 seconds, the BrainImager calculates a mean image with amplitude values in colour shades from the 28 EEG sources via interpolation of the numeric sample data. The mean value images produced in this way were integrated with the statistics software of the NeuroScience BrainImager® to form one mean value image after artefact control (see above). The mean values of the amplitude mapping may be analysed visually via analysis of the topographical differences (Duffy 1986); this method permits a differentiation between topographical reductions of amplitude values and frequency distributions of the frequency ranges.

SIGNIFICANCE MAPPING

The mean value images of the measurement stages may be compared to each other for significant differences with the t-test (Duffy, Bartels, and Burchfiel 1981). The differences are presented in the form of a significance mapping. In significance mapping, colours do not represent the shades of amplitude and frequency, but the difference probability of both mean values. Here, the t-test compares the sampled (12 Bit, i.e. 4096 pts at 256 μ V dynamic range) EEG waves of the respective mean value image with those coded numerically with the sample techniques of the BrainImager for deviations from the reference value. In the sense of a pre/post design, the undisturbed rest was chosen as reference value, and the respective trance phase was chosen for comparison. Further details on methods and techniques of the EEG brainmapping used here may be found in Fachner (2001; 2004).

FIGURE 6.



TRIAL DESIGN

After each of the four trance inductions, the test persons reported their experience in a written journal from which we quote. Two turns were performed, with an interval in between; one test person respectively was connected to the mobile brain imager in the group setting. Tom came first, then Angelika

We examined a total of four different, tested, receptive music therapy procedures (compare figure 1), the trance-inducing effects of which on the participants were measured and compared:

1. singing of monochromatic vocal soundsbody monochord; designed by H.P. Klein (see Rittner 1997)
2. Peruvian Whistling Vessels; oldperuvian whistles, trad. according to Statnekov (2003)
3. ritual body posture with rattle induction (according to Goodman 1989; Goodman 1992).

Results

The PCI test that quantifies the occurrence of characteristic structures of altered states of consciousness via 12 main dimensions and 14 subscales is a method to determine retrospectively an individual's degree of hypnotic susceptibility (Pekala 1991a; Pekala 1991b). The hypnoidal score indicates in how far the experience of a situation resembles the experience of highly suggestible persons during hypnotic induction. The score for Tom on the integrated "Predicted Harvard Group Scale" (pHGS) shows him as "moderately hypnotizable" with 6,09, while Angelika may be termed "highly hypnotizable" with 7,78 points.

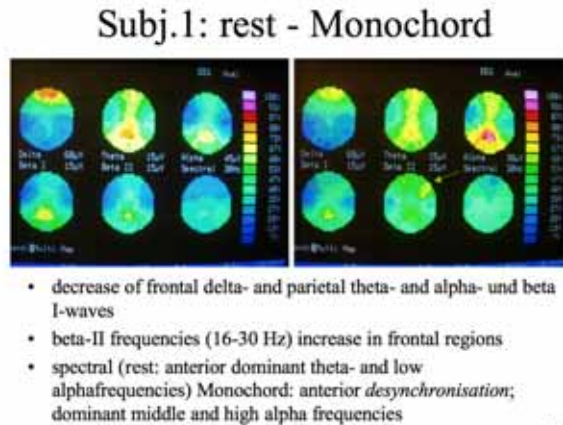
BODY MONOCHORD

For the rest EEG and the subsequent sound EEG, the test persons were placed with their backs on the body monochord, with a cap on their head containing 28 electrodes, from which cables transferred the data to the brainmapping computer next door.

The complexity of the topographic changes shown in the brain maps was the reason not to include a neuropsychological categorization and discussion of the functional significance of the regions "frontal", "parietal", "occipital", "temporal" etc. The focus of this article is on a descriptive presentation of results and a preliminary interpretation.

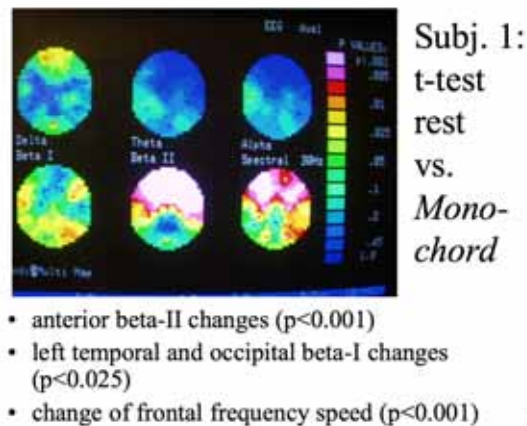
Both halves of the brain are divided into a frontal and a posterior half by the central fissure in the middle. The functions of the two frontal "quarters" may be generally be described as motoric, intentional, planning, and as the hypothetical effective location of the "self". The two posterior "quarters" have primarily sensory and receptive functions, are in charge of alertness-related processes and visual-spatial orientation. Even if this is a first orientation for the functionalities of a topographical description, the relations involved are far more complex. Details on functional correlations of brain regions may be followed up in the pertinent literature, e.g. by Kolb & Whishaw (1996).

FIGURE 7.



Compared to rest, the monochord derivation for Tom showed a decrease of the frontal Delta waves and parietal Theta and Alpha and Beta II waves. However, the fast Beta-II frequencies (16-30Hz) showed an increase in the frontal regions.

FIGURE 8.



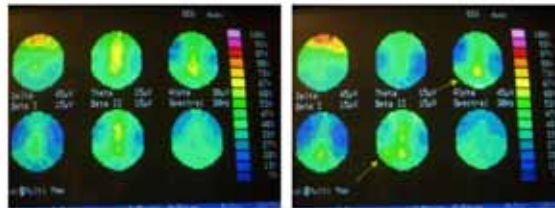
Accordingly, the t-test comparison between rest and monochord revealed highly significant ($p < 0.001$) differences on the Beta II frequency band from frontal to Gyrus praecentralis (Figure 7 on page 955).

The spectral band presenting the dominant peak frequencies and changes in frequency speeds showed an advancing desynchronization (increase of frequency speed) compared to rest.

While Theta and low Alpha frequencies were observed in frontal regions at rest, the monochord phase was characterized by the onset of a desynchronization, with a dominance of medium and high Alpha frequencies. This change in frontal frequency speeds was highly significant.

FIGURE 9.

Subj. 2: rest - Monochord

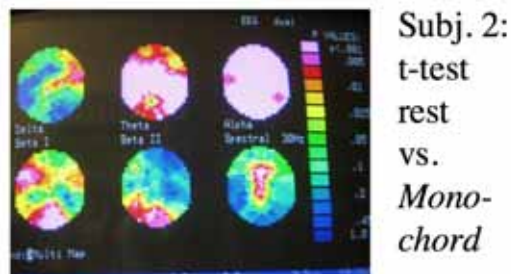


- Monochord changes:
 - Decrease of theta-Waves frontal and temporal
 - parietal increase of alpha und beta
 - Spectral range: anterior synchronisation

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In the case of Angelika, a decrease of Theta waves in temporal and frontal regions occurred compared to rest, while Alpha and Beta frequencies increased in parietal regions. In contrast to Tom, a synchronization to the front was recognizable in the spectral band during the monochord phase.

FIGURE 10.

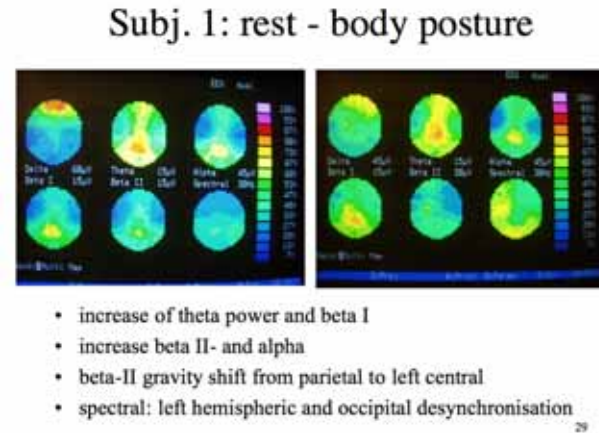


- high significant changes ($p < 0.001$)
 - alpha global
 - theta central
 - beta-I+II occipital

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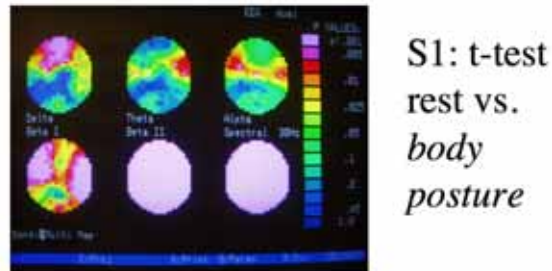
Changes were generally significant on the Alpha band, however not in frontal regions on the Theta band. Moreover, highly significant changes occurred in occipital regions on both Beta bands.

RITUAL BODY POSTURE WITH RATTLE INDUCTION**FIGURE 11.**



This figure shows the amplitude mapping of the ritual body posture. With the exception of the amplitude increase on the Beta II and the Alpha band, the amplitude mapping for Tom shows an increase of Theta and Beta I as well as a left-hemispheric and occipital desynchronization in the spectral band.

FIGURE 12.

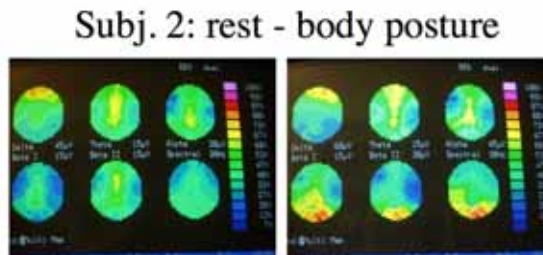


- High significant changes ($p < 0.001$)
 - beta-II and spectral changes global
 - beta-I temporal

30

The significance mapping for Tom also resembles that for Angelika.

FIGURE 13. Subj. 2 (Angelika)

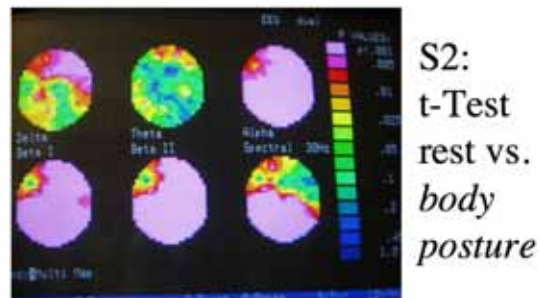


- increase theta frontal and parietal occipital along vertex
- alpha increase right temporal occipital and parietal
- beta-I + II: increase parietal occipital
- spectral band increase left hemispheric frequency speed

31

Compared to rest, the ritual body posture in Angelika combined with rattling reveals an increase of Theta waves from prefrontal and frontal and parietal-occipital along the vertex. Moreover, Alpha increases are to be found on the right, temporal-occipital and parietal. The Beta bands show distinct increases in parietal-occipital regions. The spectral band also represents a clearly visible increase in left-hemispheric frequency speeds.

FIGURE 14.



- high significant changes on spectral-, beta I+II and alpha range

32

In significance mapping, the contrast to rest is represented in highly significant alterations on the spectral, Beta I + II and the Alpha band.

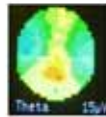
Discussion

TEMPORAL REGION EEG CORRELATE OF THE MONOCHORD EXPERIENCE

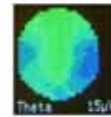
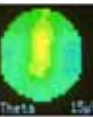
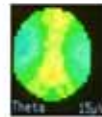
FIGURE 15.

Discussion I: temporal region

- Monochord both subjects:
 - beta increase
 - decrease of theta waves



S1 rest - Monochord



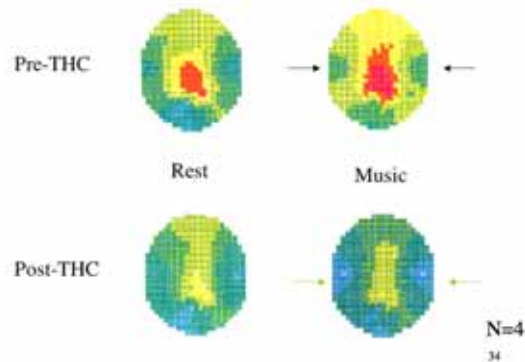
S2 rest - Monochord

33

Both test persons showed an increase in Beta waves and a decrease in Theta waves during the monochord phase.

FIGURE 16.

Discussion II: theta - temporal region



Diminutions in Theta waves, specifically in temporal regions (where primary auditory centres are located), while subjects were listening to music, were also found in a further study using this topographical EEG method. Fachner (2002) described this effect in a comparison of rest and music. Measurements with a direct-voltage EEG also revealed decreases in temporal regions (Altenmüller and Beisteiner 1996; David, Finkenzeller, Kallert et al. 1969). Fachner found in his study with the NeuroScience BrainImager® that, in addition, the activity in the temporal regions is further dampened after consumption of a psychoactive substance (Cannabis). While the EEG signature of the substance was recognizable in synchronisation and Alpha-wave increase that characteristically influenced individual reactions to the music in EEG, this study appears to show that reaction to trance induction – in the case of the monochord in particular – is rather specific to the individual test person.

Despite growing physical relaxation, the desynchronisation and increase of high Beta frequencies compared to rest suggests an active visual imagination in the case of Tom

("A cloud rises in me and through the back of my head pulls me up to great heights ... I am flying, surrounded by clouds ... thousands of houses in green and lilac on a slope ... a beautiful sight...").

The simultaneous decrease of Theta waves suggests increasing physical-mental alertness and an intentionally controlled imagination. The test person controls his own rather ecstatic experience.

In contrast, Angelika's EEG tends towards synchronization, induced by the Alpha increases. For her, the recumbent position on the monochord appears to promote a more relaxed and sensual body experience

(".. in me this turning movement .. as if I hovered in this rotation ... there were patches of haze or drifting veils and far away an unearthly music ... a feeling of calmness, of being sheltered...").

She seems to "drift" into an enstatic experience, a contemplation and deep physical relaxation. This was most obvious in the t-test in the highly significant change of the Alpha frequency in the comparison of rest and trance. Accordingly, the trance phase EEG revealed an increase in Alpha waves. Crawford underlined the correlation between Theta activity, high suggestibility and a reaction of frontal and limbic regions. Function-related hippocampus and amygdala activities (in deeper layers of the central brain) suggest a complex pattern of facilitation and inhibition of neural interaction in the limbic system of persons highly suggestible to hypnosis (in Sabourin et al. 1990). Since our two subjects turned out to differ in their suggestibility to hypnosis as a test result, i.e. revealed differences in facilitation and inhibition, this seems to influence the experience regarding tendencies towards ecstatic or enstatic experience. For Angelika, the hypnoidal score of the pHGS indicated "highly hypnotizable" (see page 954); she reacts more in the sense of a trophotropic trance with increasing low-frequency waves, while Tom reacts in the sense of an ergotropic trance with increasing high-frequency waves.

Our study reflects the effects of the monochord on both test persons in similar, subjective descriptions of hovering states, visions of cloud-like forms and changes in the body feeling.

"My impression is that I drift through space lying on the monochord" is Tom's description. Angelika: "They were very slow, but even movements ... as if I hovered in this rotating movement ... a tremendous space in grey and white, through which veils were drifting".

EEG CORRELATES OF RITUAL BODY POSTURE WITH RATTLING

How to describe the experience of a "ritual body posture with rattle induction"? Exemplary excerpts from written reports by Tom and Angelika serve as illustrations. Angelika saw and perceived herself as a "vulcano" in trance:

I see the streams of lava in orange-red seeping over the black earth. It is still happening extremely slowly but evenly. Then I can feel a large opening in my lower abdomen through which lava comes out of me, too. I see it seeping out of me, can feel it in a very sensual way, and at the same time I am lava myself. After a long interval I hear the rattles again. They sound like thundering stones. My hands become rocks, which I throw away. Rocks keep growing, and I keep hurtling them away. I still am the vulcano. All this does not feel very alarming but powerful. Then the movements of hurtling stones and of streaming lava cease. I feel light emerging in front of me. Everything is perfectly still, I am immobile, too. I can see tiny green plants sprouting from my hands, can feel them coming out between my fingers. – I feel full of power and content.” (Further details in: (Rittner 2005).)

Tom identifies with the archaeological artefact of the “olmecic prince”:

“As soon as the rattling starts, I start to drift. I see figures and objects in front of me. An altar made of stone, in the middle of jungle. The images are more what I feel than what I see. Something bright and yellow on the altar .. the brightness becomes a crown, like the head dress of the “olmecic prince”. The crown becomes larger and brighter. I see the very tall olmecic figur sitting in front of the altar. Creepers climb up all over it ... the whole place is ... grown over with plants. A tall, upright serpent ... looks at me, in the foreground. This is a very powerful, “knowing” place ... I see the earth as a rotating globe in green and blue. I watch it for some time and then I think: “and this is why the earth moves!” – The rattling stops, far too soon, a pity. I feel “dazed” for a long time. I feel I have taken in a lot of knowledge... the key to essential questions...”

Experience gained in altered states of consciousness becomes apparent e.g. in changes in thinking, emotionality, perception of meaning and a feeling of something unutterable (Ludwig 1966). A known effect is improved memory of what has been perceived during the ritual body posture. The increase in Theta waves and highly significant changes on fast frequency bands observed in Angelika, in visual regions specifically, may represent a more active access to image-like structures, analogous to a dream experience. The images and insights perceived or remembered in trance through spontaneous emotional intuition (“*I still am the vulcano. All this does not feel very alarming but powerful...*”) are possibly reflected here in the increase of Theta waves in the limbic system and of Beta waves in visual regions.

In 1990, Guttmann was the first to demonstrate in studies with the direct-voltage EEG that in the ritual body posture with rattle induction and simultaneously with the occurrence of Theta waves in the EEG, there was an unusual increase of cortical negativation (DC potential) of 2000-3000 microvolt (Guttmann 1990: 319). This indicates an overactive state of the cerebral cortex and in spontaneous EEG would

be evident in a dominance of Beta waves. Guttmann coined the term “paradoxical arousal” or “relaxed high tension” for this phenomenon.

Park et al. (2002) found changes in the EEG in the case of a Salpuri dancer in comparing rest, listening to music and memory (of a previous dance). Salpuri is a traditional dance performed by medicine men in Korea. In the phase of remembering an ecstatic trance state in the dance, frontal increases of low alpha frequencies (8-10Hz) were found as well as frontal-occipital Theta increases, compared to rest. In the comparison of rest and listening to a piece of pop music, there was a highly significant increase in the frequency of high Alpha frequencies (10-12.5 Hz) over the entire cortex. This may have indicated a difference between a primarily physical trance experience and the enjoyment felt in listening to music. 9.5 Hz was the identified peak frequency in rest and memory of dance, with an increase of amplitude energy in the memory of dance. The peak frequency rose to 10 Hz in the process of listening to music, and high Beta frequencies increased. Park supposes that the Salpuri dancer *“reaches the altered state of ecstatic trance through suppression of frontal cortex functions and activation of subcortical functions”* (Park et al., 2002: 961), i.e. that trance is characterized by Theta frequencies, the dominance of which in the EEG suggests such an activation.

BETA CHANGES

The increase in high Beta frequencies while a subject listened to music reported by Park are also known from other studies on music perception. Walker (1977) reported increased right-lateral activity while listening to classical music; Behne et al (1988) reported occipital increases; Petsche (1993) found increases in posterior right-lateral coherence, and Bruggerwerth reported music-related, emotion-specific decreases or increases of posterior Beta activity (Bruggerwerth, Gutjahr, Kulka et al. 1994). According to Petsche (1994), the Beta frequency bands indicate differentiations of music-related cognitive activity.

The conspicuous reaction of the EEG in both trance inductions with an increase of high Beta waves (16-30Hz) seems to be a further indication of the influence of trance triggered by sounds. Isotani et al. (2001) explored hypnosis-induced states of relaxation and anxiety and discussed the conspicuous reactions with high Beta frequencies and their EEG signature in emotional states.

Meszaros et al. (2002) interpreted the EEG for hemispheric differences and described a primarily right-hemispheric, parieto-temporal EEG reaction of the Alpha and Beta band in persons highly susceptible to hypnosis; he concluded that in the *“mainly emotion-focussed hypnotherapies”* (the same, p. 511), as expected, right-hemispheric changes will be dominant. In his study, persons with high,

medium and low susceptibility to hypnosis all experienced an altered state of consciousness while listening to music in a relaxed position in an easy chair. Significant differences in the “Altered State Index” were only found for the areas imagination/hallucination (compare the same, p. 510).

Consequently, the Beta changes we found for the monochord as well as for the ritual body posture seem to illustrate the emotional reactions produced by the ritual and the sounds, which in the case of Tom resulted in an anterior right-hemispheric, and for Angelika in a posterior left-hemispheric change.

Conclusions

Returning to the research questions stated at the beginning, we found and described inter- and intra individual differences in comparing rest and trance induction. In this study with two test persons, highly significant differences were found in the topographical EEG comparing rest and trance. The profile becomes irregular in the case of the monochord. The female subject recumbent on the monochord showed a more trophotropic trance, indicated by an increase in Alpha waves, while the male subject showed a desynchronization and an increase of Beta waves, which suggests a more ergotropic trance. The data available do not explain whether these findings suggest gender-specific or mood-dependent differences, or differences in susceptibility to hypnosis.

Both subjects, however, showed similar reactions in trance induction through ritual body posture accompanied by rattling sounds. In both cases, there was a simultaneous increase in low and high frequency waves of the Theta and the Beta band. This state, described by Guttman as paradoxical arousal, appears to be a specific reaction to this method of trance induction rediscovered by Goodman. We confirmed for a ritual group setting what Guttman et al. discovered in laboratory tests as early as 1990: an ecstatic trance induced by sound and body posture is characterized by a “relaxed high tension”. Moreover, the topographical EEG showed a distinct difference between rest and sound-induced activations. The temporal regions of both test persons revealed a decrease on the Theta band.

A possible answer to our question concerning Theta increases in easily hypnotizable persons was only visible in body posture; but in the monochord test we also found a tendency toward synchronization and increased low frequencies in the easily hypnotizable subject. Increases in Theta and Alpha waves during the trance phase reported by other authors were most pronounced in the ritual body posture.

These results represent only a very small part of the entire data evaluated and are of an explorative nature. The last measurement phase (compare figure 1) covers, as expected, influences of the three previous trance inductions via singing, monochord, and listening to and playing of old peruvian whistles. An ergotropic trance may well be characterized by an increase in high-frequency waves, and a trophotropic trance by an increase of low-frequency waves. The ritual body posture with rattles seems to cover both forms of reactions.

Contrary to the concern of suffering loss of control in altered states of consciousness, our repeated findings of high Beta II elements illustrate that self-control is maintained in these methods of sound-induced trance and may even give way to a highly concentrated hyper alertness in the sense of an ergotropic trance. This is confirmed by the participating test persons as well as by our test results. A welcome effect of our study would be to reduce the fears deeply rooted in our society for cultural, historical and political reasons that trance is equivalent to loss of control and susceptibility to manipulation.

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CHAPTER 19

*Historical and social influence on
Music Therapy at the beginning of
the 20th century*

**Life and Work of the Music Therapist
Vally Weigl (1894 Vienna – 1982 New
York) as an Example of early
Conditions**

Fitzthum, Elena

The institutionalized music therapy in Europe, known in Vienna since 1958, was developed from the *Reformbewegungen* at the beginning of the 20th century. Changes in society were as important as the new artistic expressions. The rediscovered effect of rhythm to body and soul had great influence not only on Modern Dance but also on psychology and medicine. Music therapist Vally Weigl was brought up in a Viennese bourgeois family at the beginning of the 20th century. She was a pianist and composer when she left with her family Austria, being persecuted by the Nazis because of her Jewish descent. She came to New York where she took up a new profession as music therapist at the Columbia University in 1953. When she died 1982 in New York, she left behind more than 20 published and unpublished reports, demonstrations and publications on that subject. Some of them are rare documents. This portrait of her life shows the development of music therapy in Austria and the USA and demonstrates its connection to the social and political background.

Different factors were of importance in the development of the music therapy work of Vally Weigl. An analysis of the historical, social and cultural conditions under which music therapy developed brings to light its interdisciplinary background which is a novelty, has been unknown until now, and places the evolution of music therapy in a new context. An analysis of the career of pioneer music therapists such as Vally Weigl can, thus, make an exemplary contribution to the history of music therapy.

It is clear that various connections between disciplines arose in the early days of music therapy which included, among others, the three largest branches of psychology of the time, namely psychoanalysis, behaviorism and humanistic psychology in the USA. All four disciplines developed under partly identical conditions and in a number of places in the same institutions. Displaced persons of the Austrian-Jewish bourgeoisie in the USA also played an important part in the process of institutionalization of music therapy in the 1940s and 1950s. Vally Weigl's classic humanistic education, her progressive world view, and her casual way of dealing with a new feminine and emancipated understanding of roles were her significant resources, as well as those of the entire pioneer generation. All of this came about as a result of her ability to adapt in foreign institutions, an ability which not only ensured her survival in her American exile, but also made her personal growth possible in the most difficult of circumstances. Seen in this light, Vally Weigl ranks as a widely prominent personality, who was an integral part of the art and therapy scene of America as of 1933.

A reworking of the role of national socialism in the development of music therapy seemed not to be necessary until now, since the birth date, or the institutionalization of the European type of music therapy, is considered to be the year 1958. In this year, the cellist Juliette Alvin founded the British Society for Music Therapy and Remedial Music¹ in London and the music therapy research group was formed in Vienna. How then can national socialism be relevant to a young discipline which only appeared in 1958? Since it can be assumed that music therapy had a longer lead time, a search for its earlier roots cannot be spared. My work is based on the assumption that the transfer of knowledge and expertise which contributed to the coming together of the theories underlying music therapy dates from the second-to-last turn of the century and somehow 'survived' World War II in order to re-surface in Europe in the late 1950s. With "early roots" I do not mean the alleged beginnings in the times of the old testament, but rather development along those lines which can be followed in retrograde from today. In this context I find it deplorable that music therapy, which repeatedly alludes to some 'primary' source², was never able to really develop a historical and scientific consciousness.

When I was first shown how much the field of music therapy had inherited from the composer, pianist and music therapist Vally Weigl in the year 2000 through the Orpheus Trust Vienna, I suspected that the life of a woman who until then had been unknown to me was of a significance similar to that of a "missing link". In fact, the scientific evaluation of the life of Vally Weigl³ immediately filled several blank spots on the map of music therapy. This especially concerns the time span between the 1930s and the late 1950s in Vienna. The vast area of music therapy's terra incognita that the life and work of Vally Weigl promise to illuminate on are, however, of a cultural and historical nature. Looking at her person in her time made it clear that music therapy in Europe emerged as a direct result of the reform movement which took place at the beginning of the century, in particular the "rhythm

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1. Maranto Dielo, Cheryl. Music Therapy in the United States of America. In: Cheryl Maranto Dielo (editor.). Music Therapy. International Perspectives. Pipersville, Pennsylvania 1993: 605-662.
 2. Samuel I, 16: 14-16; 23.
 3. Fitzthum, Elena. Von den Reformbewegungen zur Musiktherapie. Die Brückenfunktion der Vally Weigl. Vienna 2003 (=Wiener Beiträge zur Musiktherapie Vol. 5).

movement"⁴. In this, the body was a symbol for oppression and heteronomy – and vice versa for freedom.

In my attempt to reappraise the life and work of Vally Weigl and considering all the biographical aspects known to me, important questions about music therapy arose: was the development of the material for music therapy work in the USA influenced by a transfer of knowledge and expertise from Europe or did the current run the opposite direction? Was the migration of European scientists and artists of importance to music therapy? Were the theories of music therapy at the time of the pioneers dependent on the pioneers' life world and place of living and did institutional adaptation play a role in this?

Starting from the life story of Vally Weigl, I have tried to shed light on the genesis and development of music therapy in Europe in accord with her contemporary, historical, and life conditions.

Contemporary Historical Context I

VIENNA – FROM THE RULE OF THE HABSBURGS TO NATIONAL SOCIALISM

Vally Weigl was born in Vienna on the 11th of September 1894 to the court lawyer Josef Pick and his wife Charlotte, née Rubinstein.

Noticeably, the life stories of many artists, psychologists and scientists who were born at the turn of the 20th century developed along a time-axis which started in Vienna at the close of the Habsburg rule and ended irrevocably with the fascism of the 1930s. Vienna was not the only place in Europe where the enormous intensification of a new 'modern' feeling of life was to be found. 'Youth' and 'modernity' were the new catchwords everywhere, going against the conventional and rigid life-forms of the parental generation of the 19th century.

4. I refer here to a term coined by Helmut Günther. (See Günther, Helmut. *Historische Grundlinien der deutschen Rhythmusbewegung*. In: Gertrud Büchner/Peter Röthig (editor). *Grundlagen und Methoden rhythmischer Erziehung*. Stuttgart 1971: 33-69.)

In the cities of Berlin, Paris and London, like in Vienna, the homogeneity of the young generation of the first two decades of the 20th century can be explained by the following conditions: upper class socialization, often in an assimilated Jewish family, whose thinking and behavior was shaped by enlightenment, economic liberalism and humanistic education⁵. This generation was to change science, medicine and art lastingly. At the end of this time-axis stood the mass murder or exile of millions of people along with their mental and artistic resources. The professionalisation processes of different disciplines, which had begun between in Europe 1933 and 1938 had to be transferred to different countries of exile, and as we know today, re-importing these took a long time. It rarely occurred that an emigrant was invited back into the academic and university-related professional world after 1945. This applied also to psychology, psychotherapy and psychoanalysis in Vienna.

The life stories of personalities in exile make clear how many identity crises and identity losses this generation was exposed to⁶. The life of Vally Weigl, however, shows what role creativity can play in the search for solutions. This positive strength might very well have helped her in getting over the crises and ruptures; the perpetual search for new identities spurred on her adaptability necessary for her survival. Thereby, she repeatedly acquired new homes, all of which were lasting. These included music, music therapy and the Quakers.

The aspect of identity is also of fundamental importance to music therapy generally. Without the courage of its pioneers to completely re-orient themselves at least once in life, music therapy would not exist at all. With this is meant the change of profession of the first music therapists, which led them from a profession as musicians, usually pianists, to that of music therapists⁷. This fact may lead to idealization, though the pioneers of the beginning of the 20th century in the USA probably changed their professions because of economic reasons; this remains open to research.

As regards her origins, Vally Weigl defined her temporal and social origins in 1981, a year before her death, as follows:

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5. Stekl, Hannes (editor). *"Höhere Töchter" und "Söhne aus gutem Haus."* Vienna-Cologne-Weimar 1999: 11-20.
 6. Quack, Sybille. *Zuflucht Amerika. Zur Sozialgeschichte der Emigration deutsch-jüdischer Frauen in die USA 1933-1945.* Bonn 1995: 54-56.
 7. Maranto Dielo 1993: 606-613.

I grew up in a turn-of-the-century good bourgeois intellectual family milieu in Vienna (...).⁸

Even though 'bourgeoisie' and 'upper-class' are unclear terms, family history studies show these terms to point to a closed group of people⁹. The clichés of rich and cultured, piano-in-the-hall, servants, house balls, coffee circles, and "a good catch" apply to many people, not only to the Pick family. This fact shows their position in society to have been a precise and typical one. At the latest with the loss of the Austrian crown countries did the Viennese upper class get a deep crack in their self-image, and the holding up of a bourgeois facade after 1918 could only be achieved at a very high price.

Gradually that number of household help and the family wealth disappeared during World War (...), but for quite some time mother still clung to the "facade", the symbols of the respectable bourgeois intellectual family.¹⁰

In this world of Jewish liberalism the parental generation did not take on a function of mediator in the belief systems of their children. The religious world of Valerie and Kaethe Pick was represented by a single grandfather for whom the Jewish religious education of his grandchildren was important. Already here, young Valerie's ability to adapt is noticeable: she oscillated between religions from an early age. The need to oscillate remained with her throughout her life, and maybe became the basis of her survival strategy. She mastered the ability of integrating and adapting, which make change and growth possible.

The turn of the century and the first decade of the 20th century were not only marked by social and political changes, but much of the reality of Vally Weigl's childhood was to disappear forever. The illusion of an organized world was exchanged for a reality of political change and new movements, which touched deeply upon day-to-day culture. The women's movement had as a goal not only to improve the living conditions of women but also had the priority to improve their chances of being educated. This brought about a new way of dealing with the female body. The fashion of the reform movement came about in 1900. The wide, flowing dresses with hanging shoulders ended the era of the tight corselet, which feminists like Rosa Mayreder, not without reason, took as a symbol for the oppres-

8. Weigl, Vally. Early Childhood Recollections. Typoskript. Xmas 1981: 1.

9. Schnöller, Andrea/Stekl, Hannes (editor). *Es war eine Welt der Geborgenheit... Bürgerliche Kindheit in Monarchie und Republik*. Vienna-Cologne-Weimar 1999 and Stekl 1999

10. Weigl. 1981: 2.

sion of women¹¹. Vally Weigl took advantage of this newly won freedom of movement of physical and mental nature. She, as others in her generation broke with many taboos. She for instance went for walks in the mountains, went skiing and mountain climbing wearing "simple tourist clothing" when she was 17, instead of joining in the "social glamour"¹², "much to mama's disappointment"¹³. The young Valerie had gathered a circle of school friends around her. Even her composition professor in the Musical Sciences Institute of Vienna, Dr. Karl Weigl, joined her and her friends in these activities. Both Dr. Weigl and Vally loved music and nature and they were married in 1921. The love for nature which she already had as a child and young girl remained with her even while she was in exile in the United States. She composed chamber music with themes taken from nature motifs.

A further development in the freeing of the female body, which spread through the reform movement, was free dance¹⁴. At the turn of the century, modern dance came from the USA to German and Austrian stages. Four women took the lead, each in her own completely new way: Isadora and Elisabeth Duncan, Genevieve Stebbins and Bess Mensendieck. They abandoned the strict and angular movements of Russian ballet which had dominated European stages until then and which had had the dancers perform in tight corselets. The four American women performed in wide translucent dresses and with them, the Art Nouveau use of forms the came into being.

For a while, lively and soft movements dominated the performing arts. Vally Weigl was also seized by these new impressions. Still in New York and already over 60 years old, she danced at the Jaques-Dalcroze School in her leisure time¹⁵.

11. Mayreder, Rosa. *Das Haus in der Landskrongasse. Jugenderinnerungen*. Vienna 1998: 146.

12. Weigl. 1981: 4.

13. Ibid.

14. It must be mentioned here that all these innovations were mostly significant to the women belonging to the educated bourgeoisie. The difficult economic conditions of the average woman did not allow her to dwell on the 'freeing' of her body. However, during the labor movement from 1918 to 1934, female workers were exposed to the new body culture by organized efforts of associations and leagues.

15. Kindly contributed by Vally Weigl's grand daughter Kit Potter during a conversation with the author at the Orpheus Trust in 2000.

Emile Jaques-Dalcroze (1865-1950) was, in his time, the communicator par excellence.¹⁶ In the spirit of the reform movement, he developed the basis for a new artistic trend; the rhythmic movement. This developed from his technique of including body movement in his teaching of solfege. His work with architects, set designers, make-up artists, pedagogues, psychologists, authors and painters during the Hellerauer period as of 1910 is legendary. The basis for this more holistic approach to teaching was the belief that all arts are equal. As he started working in Switzerland, he observed that students understood music better if notes, rhythm and sounds were connected with movement. The real novelty was his understanding of rhythm: Jaques-Dalcroze interpreted it as a living phenomenon, which accompanies people as well as art. The model he used, as many others in his time, was that of the ancient Greeks. This enabled the appearance of a new humanistic trend of collective reflection among the intellectuals of his day. In ancient Greece, rhythm was made up of speech, gestures and movement; in this time, people were still "whole".¹⁷ Incidentally, such seemingly different characters as Rudolf Steiner and Carl Orff were to base their life work on this thought. In tune with the changes occurring at the turn of the century, rhythm became a force able to liberate, help create a feeling of oneness, and placing man in context with his cosmos; a cosmos based on the same rhythmical and mathematical laws taught by the Pythagorean school of thought.

It must be noted here that this new rhythm movement unintentionally handed the sprouting national socialism a new medium the full effect of which was to unfold only later and under the direction of national socialism: rhythm, separated from its vitalizing functions¹⁸ could make masses march to marching music to an extent which its supporters never dreamed of. This perverted and unwanted development forced many personages, such as Jaques-Dalcroze, to emigrate, outwardly as well as inwardly.

Let us return to the time before the instrumentalization of rhythm. The influence of Jaques-Dalcroze's emphasis on body and rhythm was to be felt throughout the first

16. Fitzthum 2003: 30-34.

17. Fitzthum, Elena. In illo tempore. Vom Umgang mit der Zeit in der Musiktherapie. In: Wiener Beiträge zur Musiktherapie Vol. 3. Vienna 2001: 139-154

18. Or, speaking with Daniel N. Stern: "(...) separated from the *Vitalitätsaffekten* (vitality affects)", see also Stern, Daniel N. *Die Lebenserfahrungen des Säuglings*. Stuttgart 1992: 83-93.

decades of the 20th century and help new artistic and therapeutic methods develop, which in part led directly to music therapy.¹⁹

The discovery of the synergetic effects of the body in connection with rhythm was, at that time, already of great importance and actually had been an object of research in the early 19th century. Karl Buecher (1847-1930) wrote *Arbeit und Rhythmus* (work and rhythm) in 1896, which received a lot of attention at the time. He was a social economist and journalist and he delivered important socio-political impulses through his publications, from which music science was to profit. For instance, he examined the effects of the singing of work songs in European but also in 'primitive' cultures and thereby proved the efficiency-increasing effect of music and rhythm. His publication, which was quoted by Jaques-Dalcroze and Vally Weigl, may be seen as an intellectual starting shot for the German-Austrian rhythm movement.

Buecher's concept played a central role in the subsequent analysis of Vally Weigl's music therapeutic factors (*Wirkfaktoren*), including, according to Weigl herself, rhythm and therapeutic bonding. In particular, she implemented these thoughts in her work with physically disabled children.

Some of the children who hardly could stand on their feet or walk, would try to dance or "practice for a parade" if you played an inciting rhythmical dance or march for them; and this in turn encouraged them to practice walking then more effectively.²⁰

Let us return to the original rhythmic movement: the new theories resulted in innovations in many disciplines. It was therefore not a coincidence that many personalities who found a common denominator in their work with body and rhythm, were able to develop and excel in the overlapping areas of art and philosophy, art pedagogy and remedial education, dance and rhythmic gymnastics: rhythm as a trans-historical and transcultural phenomenon, rhythm as the companion of humankind from their earliest origins.

It is remarkable that musicians and dancers dealing with rhythm were working within the occupational intersections of disciplines where rhythm played a key role, and contributed knowledge and expertise significant for early music therapy. Regardless of her protagonists'²¹ different views of the world and of man, she con-

19. See footnote 3.

20. Weigl, Vally. *The Handicapped Need Music*. Typoskript. Vienna 1954–1956: 9.

tinued her search on a common level of observation: how are people and rhythm connected with each other and how can I apply music to healing and education. Emile Jaques-Dalcroze (1865-1950) and Mimi Scheiblaue (1891-1968) were especially important here, and contributions were also made by: Elsa Gindler (1885-1961) and Heinrich Jacoby (1889-1964), Dorothee Guenther (1896-1975) and Carl Orff (1895-1982), Rosalia Chladek (1905-95), Hans Kayser (1891-1964), and Rudolf Steiner (1861-1925).

Also Vally Weigl had the ability to leave her mark in different areas, and her publications on music therapy of the 1950s, 1960s and 1970s in the USA are proof of her wealth of interdisciplinary background, which could only be described by the phenomenon of rhythm. She ascribed to it the greatest therapeutic effect and thereby conveyed a clear and lasting image of music therapy to the professional circles of the time.

It was Vally Weigl who brought the legacy of the rhythm movement to music therapy. Entirely in tune with the reform movement, she wrote the following in the introduction of one of her publications:

As long as the Earth has existed, rhythm has made itself felt in the succession of night and day, of sun and moon, of the seasons, of ebb and tide, and of the course of planets.²²

She regretted that, "free body movements as [an] instinctive means of expression seem to be more and more inhibited in adult life."²³ She had already worked out this point of view in her youth.

It is most likely that the potential released by socio-political and life reforming processes would very soon also have led to an early music therapy approach in Austria and Germany, had not the era of national socialism taken care of eliminating these new ideas in two ways. On the one hand, most of the people which were part of this new movement were either killed by an unprecedented death machinery or were forced to flee. On the other hand, the 'new' fascist ideology knew very well how to absorb elements of the life reforming movements and give them new connotations.

21. A closer look at these views of the world and of man reveals that they all derived from neo-humanism and are losing discriminatory power.

22. Weigl, Vally. About Rhythm and Its Effects on Kinetic Impulses. In: Bulletin of the National Association for Music Therapy (NAMT). May 1961: 9.

23. Weigl 1961: 9.

Vally Weigl managed to flee to the USA while her sister Kaethe Leichter, with whom she at that point had a tense relationship, was murdered in 1942 in the Ravensbrueck concentration camp. In fascist Europe, the reformatory force of the reform movements ended in new labeling such as "strength through joy" and "triumph of the will"²⁴.

Historical Context III

USA AFTER 1930

The transfer of European education and science brought on by those in exile had an effect on the local institutional scene. The example of Vally Weigl shows what a great influence the American working conditions had on the therapeutic field of work, and how valuable the expertise imported from Europe could be.

Some American historical background: the 25th of October, 1929 came down in history as Black Friday. The crash of the stock market in New York led to a worldwide economic crisis, and the social structure fell apart (also) in the United States due to the reality of mass unemployment. 1933 marked the end of the worldwide economic crisis. It was the year in which Hitler came into power in Germany and Franklin D. Roosevelt, who had been elected president of the USA in 1932, initiated the "New Deal"; a turning point in American social politics. This new course of action was meant to introduce improved relations within social and economic life, in order to come to terms with the economic problems and their effects. This New Deal concept brought about an atmosphere of change, and the field of psychology profited from the dynamics of this atmosphere: test psychology, behaviorism, logical positivism, and pragmatism were the order of the day and quite a few psychology columns in newspapers trivialized the image of psychology, with the effect that it became ever more present in the minds of the American people.

As of 1933, many European colleagues entered into the American scene, and among these were many psychologists who were specialized in Gestalt psychology and psychoanalysis. This from an American point of view, enormous competition needed to be employed. Programs were created with the help of money from foundations and donations, and these made it possible for many psychologists and medical doctors to find employment. In this way, the New School for Social Research in

24. Title of a movie by Leni Riefenstahl 1934.

New York was reconstructed with money from the Rockefeller foundation. The Mount Sinai Hospital also became a (subsidized) occupational place of refuge for migrants.

In the era after the war, clinical psychology boomed. The need for many war veterans to be physically and psychologically treated was significant, and for the first time this was done in group sessions.

In the 1960s the phenomenon of protest and alternative culture came into being, the Vietnam war raised existential questions among the American young people. The civil rights movement, the black power movement, the women's movement, the BEAT and hippie movement, they all focused on the rights of self determination, freedom and peace and, thus, essentially appealed for new peace and social policies.

Also Vally Weigl's professional life fit in well with the American scene from 1938 onwards. Right upon arrival, she started teaching piano privately as well as teaching languages and from 1942 to 1949 she was a freelance musician with the Society of Friends in Westtown School in Pennsylvania. When her husband died on the 11th of August, 1949, she was 55 years old and had to start all over again in New York. Shortly after her husband's passing she broke her shoulder and this gave her life a new direction. The complications of the injury meant that she would no longer be able to play the piano in a professional context. She coped with the physiotherapeutic program through her own discipline and discovered that the necessary training was less painful and easier to carry out if combined with music. This once again proved to her the previous theories of Karl Buecher.

This experience, and the fact that unemployed musicians traditionally were hired to care for the sick in the USA may well have moved her to start her masters degree in music therapy at the University of Columbia, which she completed in 1953. She was 59 years old then, and from then on worked, taught and published as a music therapist.

Historical Context IV

AUSTRIA/GERMANY/SWITZERLAND TRANSFER OF KNOWLEDGE AND EXPERTISE IN THE FOREFRONT OF MUSIC THERAPY

While the development of music therapy in America was accompanied from early on by various measures for its institutionalization²⁵: social-professional organizations, congresses, periodicals, etc., and its content was emphasized by a strong receptiveness, the first therapy-like activities in Europe with the targeted application of music came about from entirely different sources. The focus of all those new approaches which finally led to the establishment of music therapy in Vienna in 1958, 20 years after Vally Weigl's exile, was rhythm. This fact already implied an active (as opposed to receptive) work approach focused on experience, action and the body. The professional community comprised of all those who worked with this new approach was interdisciplinary. The new courses of action together formed the field of remedial education.

The musician Emile Jaques-Dalcroze, who worked in Geneva, moved to Hellerau near Dresden, the Mecca of the body movement scene of the day, to run the School for Rhythmic Gymnastics. From here his students spread the unit of rhythm, body and expression that he taught. For Jaques-Dalcroze, sensorial perception was the most important instrument for the creative artist and this belief had an influence on dance, education and musical education. In 1913, Heinrich Jacoby also worked in Hellerau and was joined by the young rhythmic artist Elsa Gindler in 1925. As early as 1913 he began to carry out experiments to find out whether people could really be unmusical. This question occupied him for the rest of his life. He, who was actually also a friend of Alfred Adler's, came to the conclusion that there is no such thing as a lack of musical ability, but

(...) that the issue is one of functional correlations and a general behavioral problem, which – demonstrated through the subject matter of music – applies, as an analogy, to the processes of perception for all the senses and for all other areas of expression such as movement of the body, language, pictorial expression and for thought processes.²⁶

25. See the contribution by Alan Solomon, who describes the further context of music therapeutic professionalization in the USA.

26. Jacoby, Heinrich. *Jenseits von "Begabt" und "Unbegabt". Zweckmäßige Fragestellung und zweckmäßiges Verhalten – Schlüssel für die Entfaltung des Menschen*. 5th revised edition. Hamburg 1994: 9.

This and others of Jacoby's thoughts touched upon the core of the music therapy to come and, thanks to Alfred Schmoelz, they were incorporated into the Austrian curriculum. They postulated in advance the concept of a heart-soul-body unit, the functioning of which can be understood and changed through music.

Rudolf Steiner himself used, among other things, a related approach, when in 1912 he laid the foundation stone for eurhythmics in Kassel. He also referred to a rhythmic artist, namely the famous gymnast Bess Mensendieck:

One can of course be a good theosopher and also do Mensendieck gymnastics (...) . However, one could also do something similar on a theosophical basis (...).²⁷

Another rhythmic artist, Dorothee Guenther, a student of Bess Mensendieck's, left her mark for music therapy in 1924. She founded the Guenther School in Munich in this year; a school for gymnastics and dance. She asked Carl Orff to be the musical director. He composed his first school piece so the students of the Guenther School could accompany themselves as they danced. Many of his and Gertrude Orff's significant impulses were adopted in the field of music therapy. As in the autumn of 1973 the Institute for Musical Social and Remedial Education in the Mozarteum in Salzburg was founded, Wilhelm Keller was asked to be the director. The musical score was not to be played in a strict manner, but should be a model for improvisation. Keller led the way for the field of remedial education. Music, if always interpreted in a multisensory way, begins to assume its place in the work with sensorially disabled people.

This approach was pursued independently by the Swiss student of Jaques-Dalcroze, Mimi Scheiblaue. Scheiblaue studied in Hellerau and from 1926 to 1968, she was to work tirelessly with sensorially and physically disabled children, train kindergarten and special school staff, and build up a net of international contacts. Vally Weigl met her in Zurich at the Remedial Education Institute on the occasion of one of her trips to Europe in 1953. In the USA she wrote:

There Mimi Scheiblaue has designed remarkable techniques for improving attention span, concentration, coordination and body control in all kind of mentally or physically handicapped children (...).²⁸

The Swiss lady is repeatedly mentioned in Vally Weigl's publications, and it is praiseworthy, that Weigl always stated the authorship of Scheiblaue's techniques

27. Rudolf Steiner quoted in Günther 1971: 51.

28. Weigl 1954-1956.

openly. In her work with physically disabled children, Vally Weigl took advantage of the possibility to favor the establishment of kinesthetic pathways, through the connection of body movement and sound. These new approaches later helped with the 'translation' of movement into 'words'. She saw how enjoyable this work was for the children also how this work could act as a preparation for logopedic and physiotherapeutic programs within the respective institutions.²⁹

In children with behavioral problems she noted the 'social' function of rhythm in group work. Here too, homogeneity within the group was attainable using rhythmic exercises and games, and this was the priority for this type of clients, the children enjoyed themselves and were motivated to continue learning.

Through the use of selected musical games, she made it possible for socially inhibited children to take on a leading role within the improvisation groups. What made her stand out was her humanitarian attitude. She excluded no one from her music therapy. If necessary, she would quickly compose a particular piece for a specific client. Most important of all was that everyone found their own place within the group. Everyone must feel useful, must experience the feeling of being part of a group.

She opened a new access to the outside world for deaf-mute people through the tactile experience of music (using the vibrations of the piano and the drum).

She worked with patients in pain and managed to reduce their pain by playing relaxing music or their favorite music to them. This approach is being observed and scientifically researched today thanks to Ralph Spintge and Hans-Helmut Decker-Voigt in Hamburg.³⁰

In her work in the field of geriatrics she discovered how important it was that the elderly, many of them former refugees, came in contact again with songs from their old home countries. In her work with psychiatric clients she recognized already in the 1950s the relieving effect of music. Vigorous drumming could have a freeing effect and sad music could make them cry. Blocked feelings could be released in this way, it is a true emotional outlet.

29. Weigl 1961.

30. See also the contribution by Hans-Helmut Decker-Voigt.

The professional concept of the music therapist Vally Weigl was quite mature and her ability of reflection was enormous. And this at a time (1958) when people in Europe were beginning, for the first time, to acquaint themselves with music therapy. Long before the findings of Daniel N. Stern about "intramodal equivalences", "affect attunement" and "*Vitalitätsaffekte*" became standard knowledge in the fields of music therapy and psychotherapy. She was using music just like any other of the languages she mastered. And in this way she offered her clients the possibility of using music as a language, of exploring a new medium for expressing their feelings, and of finding a better and more enjoyable relationship with their own body.

CHAPTER 20

Beyond Angst

Gabbrielli, Antonio & Primadei, Adriano

Introduction

Music therapy is now recognized as a valid aid in the field of palliative care. Even in Italy, one of the European countries where music therapy is attempting to make up for significant historical and cultural delay, it has been utilized for some time now in this specific field. In this contribution we will examine the case of a young man of 24, and focus on certain specific characteristics of our therapeutic intervention. We feel this case is particularly pertinent because it prompts reflection in more general terms on the meaning and objective of palliative care, and on how music therapy and the language of music can be inserted in this context.

Palliative care and music therapy

From a medical standpoint palliative care acts on the physical condition of the patient to make the course of illness more bearable. Nevertheless, because quality of life is not a matter only of physical wellbeing, palliative care also addresses the

psychological, social, spiritual and existential aspects of the patient, through the intervention of different professional figures such as psychotherapists, music therapists, social and spiritual workers and trained volunteers, whose efforts supplement those of doctors and nurses.

In the course of the illness, as the patient approaches the end of life, the psychological and existential aspects become increasingly important and decisive, because the pain and anguish can become total, and if not controlled and addressed can lead to a state of depression so void of meaning as to render any pharmacological treatment ineffective.

It is here that psychotherapeutic intervention becomes fundamental, in an attempt to reinsert the patient's experience in a meaningful context, permitting the subject to process that experience and maintain a connection with his innermost reality. In fact, often in these situations the anguishing wound can actually trigger a process that brings the subject closer to his own inner truth. Our viewpoint is based on that of one part of psychoanalytical thinking, which takes its distance from the notion that individual history is totally determined by what has happened before and, in particular, by the experiences of childhood. Thus, for this current, individual history cannot be seen as mere repetition of crystallized structures of the unconscious. Outside of this determinism, the subject is seen as an entity that can and must fulfill itself in the future, as a precise ethical task to be completed. In this perspective, the therapist's activity in the field of palliative care becomes crucial. The care takes on particular importance because it attempts to shift its direction from memory of the past to perception of an echo that comes from the future, a position that constitutes the possibility of freedom for the subject with respect to any determinism.

Serious illness faces the individual with the question of death, the most radical limit of human existence. What is this encounter with death, if not a sensation of the void, a wavering on the edge of nothingness? When, in the experience of the terminally ill patient, the world is emptied of meaning, brutally taking an inert material character, it becomes the place that silently awaits his disappearance.

The intervention of the music therapist comes into play when verbal work is no longer sufficient. The terminal patient finds himself in a borderline condition in which the brevity of space and time may force him, in spite of himself, into the prison of the inexpressible. In this sense music intervenes to form a filter that recreates the symbolic context that has been devastated by the traumatic experience of the perturbing impact of the real (the term is applied in the sense used by Lacan). This is a human condition that goes beyond the philosophical and religious convictions of each individual. This does not mean that faith should be considered merely

a style of sublimation, but that even the most profound religious sentiment cannot help but come to terms with the sense of abandonment caused by the closeness of death, as is borne out by the phrase in the Gospels «Eli, Eli, lamà sabactàni?» (Matthew 27:46)

Our model of music therapy sees music, with its style and formal organization, as the main element with which the therapeutic process evolves. As in verbal psychotherapy, the relationship between the therapist and the patient is essential in this process. But in music therapy the musical language that develops in free improvisation is the fundamental therapeutic factor. One of the main functions of the music therapist, through free improvisation, is to work in real time on musical material suggested by the patient, in order to facilitate processing of psychic content.

The structure of the clinical improvisation may vary significantly, in keeping with the problems to be addressed, and the patient's cultural context of origin contributes to create the conditions through which the improvisation is oriented toward a given musical style. Nevertheless, there is a close connection between the pathology confronted and the musical development of therapeutic treatment. Moreover, in the case of palliative care we must keep in mind that the trauma is truly connected with the breakdown of the body, and is therefore present at a psychic level without any veiling.

Physical nature and artistic expression

To clarify what has been said thus far, and to facilitate comprehension of the musical materials of the clinical case that follows, we would like to present a more general overview of how, historically, the irruption of the real has taken form in artistic and musical language.

Starting with the artistic experience of the Surrealist movement, the concept of the artwork as a revelation of the unconscious, of its impulsive force, laid the groundwork for a paradigm change that challenged the notion of the function of beauty in art, a function that had been eminently one of “veiling” and sublimation of the real through treatment on a symbolic level. In place of this notion of beauty, an increasingly literal representation of impulse appeared, a radical position that shifted the aesthetic center of gravity of the artwork toward an obsessive presence of the body, as we can see, for example, in the performances of the Orgien Mysterien Theater of Hermann Nitsch.

This irruption of the body in the artwork has also become common in pop music, where there is an increasingly evident allusion to the perverse presence of the body's organs, in a sort of idealized exhibition of horror and obscenity. Just consider, for example, the self-destructive antics of Punk, or the music and images marketed by *Aphex Twin*, *Nine Inch Nails* and *Marilyn Manson*, just to name a few recent acts on the pop music scene.

Where symbolism collapses the Real bursts in, with devastating effect. Certain art-forms approach psychosis. According to the teachings of Lacan, in psychosis the subject encounters a real without symbolic contours; a persecutory Real that assails the subject's body and thoughts, abusively invading him.

Nevertheless, beyond extreme, literal forms, the irruption of the Real has also been expressed in contemporary art without a loss of its symbolic-formal organization, as in the case of Alberto Burri, who in works like the "*Combustions*" (figure 1) or the "*Sacks*" (figure 2) conserves an explicit reminder of the presence of the body, though the discourse moves in the opposite direction: from the presence of material it re-ascends to the level of art seen as dramatic representation and the realm of beauty.

FIGURE 1.



FIGURE 2.



In the last works of Paul Klee we can observe an artistic process that is interesting not only for its aesthetic implications, but also because it bears witness to a processing, through art, of the trauma connected with illness and death. These works belong to the final period of Klee's output, when the artist was afflicted by systemic scleroderma, the fatal disease that gradually stiffens the organism, and killed Klee in 1940. In these paintings we find certain fundamental themes of the existential condition of a victim of a serious pathology: the degeneration of the body and its disturbing presence (figure 3), the separation from the human community and loved ones, the gradual slide into anguish caused by awareness of the void, but also conscious shouldering of one's human destiny.

FIGURE 3.



In the watercolor entitled *Separation* (figure 4), for example, a female figure appears, separated from her man, whose body appears to be dismembered, while his lower limbs are about to disappear in an eddy of putrid color.

FIGURE 4.



In one of the very last images made in 1940, *Wherefrom, where, where to* (figure 5), a figure is situated against the blue background of infinity. The legs push it forward but the head is turned back and downward, as if to look at the space left behind. One arm and one leg are white, while the rest of the figure is light blue, like the clothing: an allusion to fusion with the beyond, the unavoidable nature of one's fate.

FIGURE 5.



While in Paul Klee the attribution of meaning to traumatic experience is a spontaneous process, clinical experience demonstrates that the achievement of such depth

in approaching anguish is a process that seldom happens spontaneously. Therefore the role of the music therapist becomes fundamental to support and guide the patient toward the possibility of accepting his own limit, to live his own individual path as fully as possible, in spite of the difficulties and timing imposed by disease.

The clinical case: Leonardo

In our discussion of the relationship between a work of art and the irruption of the Real, we have highlighted how an artistic experience can at times be similar to a psychotic experience. Starting from this consideration, this music therapy treatment had to deal with the need to adopt a musical language which allowed the patient to reconnect with his own personal story and his own emotional world. At the same time, as his musical experience was basically tied to decidedly hard rock, it was necessary to find a way to propose this style in therapy, mitigating the most harsh and explicitly destructive musical and symbolic aspects.

The anguish of the terminally ill subject may often resemble psychotic anguish, but when this happens the capacity to tolerate the psychic pain connected with traumatic experience remains structurally intact, though it is impaired. In fact, with the approach of death the subject often is no longer capable of bearing the impact of the real, because the pain and the perception of the void are so intrusive as to make any thought impossible. Music therapy can facilitate, through an approach that takes the extremely precarious state of the patient's psyche into account, a path leading from the total suffering caused by the disease to a relativizing of that suffering, restoring the possibility of giving a new meaning to what has already happened, to redescribe experience in a new way.

Leonardo – this is the name of the patient whose case is examined here – was a young man of 24 suffering from neoplasia. His overall conditions had deteriorated seriously. After a unsuccessful operation, Leonardo was tirelessly assisted by his mother. The doctors attempted, in substance, to improve his overall condition as much as possible. The family doctor suggested music therapy, because Leonardo was a drummer, played the guitar, and had always had an excellent relationship with music. The music therapy began when he was already in critical condition: he was very thin, had difficulty getting out of bed, and was living in an evident situation of mute psychic isolation. He had very long hair and a long beard, and seemed to have completely given up on any personal grooming.

We can observe three different phases in this therapeutic path. An initial phase, devoted to reconstruction of a protective context with respect to the traumatic experience, involving listening to and discussing pieces of music that were a part of his memory. In a second phase characterized by free improvisation Leonardo discovered the possibility of playing freely, together with the therapist, and of dealing with certain elements connected with the trauma in the improvisation. The central focus of the third phase of the treatment was the emergence of a song Leonardo had already composed but had never played for anyone before. The music therapy sessions were conducted in the house in the country where Leonardo lived with his mother, not very far from Florence. The sessions varied greatly in terms of duration, depending upon the needs of the patient and the timing imposed by the session itself. In our first encounters, as he was to tell me later, in another session, Leonardo was skeptical about the possibility of music therapy to help him, essentially because he thought that a music therapist would never be able to understand his musical style: he had always listened to and played rock. The initial moments of our first meeting were difficult, because I sensed that Leonardo's outer silence reflected an inner emptiness, and I knew I would have to respect that silence, weighing my every word, as it could have an enormous effect in determining whether the therapy would continue. The first two music therapy sessions were devoted to an attempt to revive his inner world, listening to some of his favorite records and talking about them. Some of his favorite songs were particularly striking, and though they were not literally utilized in the improvisations, they contributed to create a shared musical context. I would like to listen to two short examples from these songs:

1. *Dream Brother* by Jeff Buckley
2. *Garden* by Pearl Jam

Listening to this music gives us an indication of the particular musical language utilized in this treatment. In fact, we can notice that this music was the inspiration for certain harmonic, rhythmic and formal characteristics of the improvisations. It is starting with these premises that we can interpret the musical material utilized in this clinical case, namely taking into account the fact that certain musical elements like repetition and functional tonal (and at times modal) harmony are normal features of rock music. Obviously the choice of a given language is, in any case, connected with a psychological need. In this case the repetition typical of rock constituted a useful scaffolding to contain the emotions of both the therapist and the patient.

After having listened to these songs and talked about them, at the end of the second session Leonardo told me, "I agreed to see you because my doctor advised it, but I

wasn't really convinced that undergoing this therapy made sense; I thought you would be different. Now that I've gotten to know you, I think I would like to continue with these sessions". He also talked about the loneliness he was going through. He told me certain friends came to visit him now and then, but that he felt increasingly uncomfortable in their presence. When he was with them he felt excluded, and he noticed they had trouble looking him in the eye. This difficulty caused him particularly pain, because he could glimpse the sign of an unavoidable sentence. Before we parted he said, "You're the only person with whom I feel at ease, because you're the only one who doesn't look at me *like that*".

In the days leading up to our next session I improvised many times on the guitar, trying to make contact with the resonances that had emerged from our encounter. At this point the difficulty in the treatment lay in finding the right musical instruments for the improvisation. I decided to bring a violoncello, two different types of lyres and a guitar. I selected these instruments for their timbral qualities and their harmonic and melodic possibilities.

At the start of the third session I asked Leonardo to choose the instruments for the improvisation. He chose the smaller lyre for himself, an instrument with both drone strings and strings tuned in a modal scale, and asked me to play the guitar. After a few moments of silence, the first improvisation began.

FIGURE 6.

Leonardo,
First Improvisation

The musical score is written for two instruments: Lyre and Acoustic Guitar. It consists of three systems of staves. The first system (measures 1-4) shows the Lyre playing a melody with notes G4, A4, B4, and C5, while the Acoustic Guitar provides harmonic support with chords and single notes. The second system (measures 5-8) continues the dialogue, with the Lyre playing a descending line and the guitar responding. The third system (measures 9-16) shows further development, with the Lyre playing sustained chords and the guitar playing a more active melodic line. Dynamics such as *p*, *pp*, *mp*, and *mf* are indicated throughout the score.

In these initial bars (figure 6) we can already find some important elements of the therapeutic process. This first musical dialogue created positive conditions for the development of the improvisation. From the first notes I tried to insert Leonardo's musical output in a formal structure, creating the conditions for the development of further variations.

The first measure is characterized by the guitar's imitation of the B from the E-B fifth played by the patient on the lyre. The initial A of the guitar is an appoggiatura of the B, and has a structuring function for the melody line. The first note of the second measure of the guitar is a B that descends to A. The structure of these two bars, the specular development of the melody, indicates interdependence between the therapist and the patient in the musical construction. The third bar returns to the rhythmical scheme of the first. The guitar pauses for a quarter-note rest. This rest allows Leonardo to develop the musical discourse while I listen, with the aim of developing the material he generates. The construction of the melody brings both instruments to the *finalis* E. The second semi-phrase (bars 5-8) features an inversion of roles with respect to the previous measures. The tenor role in bars 1-4 was played by the lyre (figure 7):

FIGURE 7.

In bars 5-8 (figure 8) the tenor role is passed to the guitar.

FIGURE 8.

Leonardo developed the melody of the guitar, then entering the region of the dominant together with it (bar 7) and resolving the cadence toward the *finalis* (bar 8). The polyphonic structure of this phrase is evident in its oblique direction and its distribution between the two instruments. I would like to emphasize the fact that Leonardo was struck by how this musical construction could emerge in real time in the improvisation. While in the first bars the melody is constructed in the Doric mode, starting in the ninth measure the lyre hints at a melody in the Phrygian mode. The guitar's imitation (bar 10) moves under the light sound of the lyre, which defines a space composed of bichords and single notes that gravitate around the region of the subtonic and the fifth. After stopping on E, the guitar plays an ascending scale with repeated notes until A, in unison with the lyre (bar 14).

In our conversation following this first improvisation Leonardo spoke of the deep emotion he felt at the appearance of this unison. As in the case of the first cadence, once again the unison marked the most recognizable moment of synchronicity generated in the improvisation. As Jos De Backer and Jan Van Camp have pointed out, generally in this moment of the therapy the patient and the therapist have the impression of being able to freely make music together, simultaneously experiencing interdependency in creation of the musical structure, and autonomy in the free development of the musical material. At times, with certain patients, this moment is achieved with great effort, and most of the therapy can be said to be directed toward the achievement of this objective. In the case of Leonardo, the instantaneous appearance of this moment indicated that the starting point for the therapy was this synchronicity. Undoubtedly the first two sessions devoted to listening and discuss-

ing pieces of music had created the conditions for the opening that happened during this first improvisation.

After this introduction, my accompaniment begins on the chord of E minor, in this case corresponding to the first step of the Phrygian scale proposed by Leonardo in the ninth measure. While initially the lyre and the guitar interweave in an arpeggio, as the improvisation develops Leonardo begins to vary the musical material, suggesting new melodic solutions.

As Jos De Backer and Jan Van Camp have pointed out, in the music therapy context every musical event is born from a preparatory silence that grants the therapist the possibility of resonating with himself and the other. In this silence the music therapist becomes receptive to the presence of the patient. This condition leads to perception of an “anticipated inner sound”, or the perception of the musical presence of an inaudible sound that arises in the therapist in the moment he focuses on making music with the patient.

Another musical example, still from the first improvisation, demonstrates the importance of this principle in the development of the improvisation. After several moments of silence the sound emerges, almost imperceptibly, simultaneously from the lyre and the guitar, turning the improvisation in a new direction.

In all the encounters with Leonardo the verbal part of the session was always devoted to comment on the moments of music that emerged during the improvisation, with only indirect mention of the problems connected with his illness. The music therapist could sense Leonardo’s reluctance to even touch upon any theme that might have a direct link to the emotions and sentiments involved in his situation. Only in a few fleeting moments of the first improvisation was it possible to recognize the emerging of the trauma, usually in variations on the musical material, as in this fragment that particularly intrigued Leonardo.

In this fragment an A-D sharp tritone in the lyre inserts itself in the circularity of the sound. The guitar gathers the note, making it part of the accompaniment. In the recording one also hears the microphone as it falls, noisily, accentuating the traumatic character of this passage. When he listened to the recording Leonardo remarked on the dramatic quality and the discontinuity caused in the harmony by the introduction of this “harsh” interval. The diminished fifth was to play a crucial part in another very important moment of the therapy, as we will soon see. It is interesting to note that a musical framework based on a tonal-modal syntax, in which variations and harmonies remain limited to a sphere of great predictability, offers possibilities for confronting

the most difficult and at times painful moments by starting with minimum discrepancies within the musical fabric.

The following week Leonardo's appearance was quite different. I found him sitting on the bed. He had cut his hair, keeping it long, but trimming it for a more orderly look. Instead of the beard he had a well-groomed goatee, and his overall condition seemed to have improved. As soon as I sat down beside him on the bed he showed me the catalogue of a store selling percussion instruments. He said that during the week he had thought about buying a new drum set, and he described the characteristics of the models that interested him. He also asked me if I could help him set up his laptop computer so he could use it to make music. Rediscovering music through the aid of the therapist had revived his relationship with the world. He had rediscovered the energy and vigor that had been erased by the disease, and a new enthusiasm led him to plan projects for his musical future. The vitality Leonardo communicated was in evident contradiction with what he was experiencing because of the tumor. The transfer that had emerged in therapy had brought with it the negation of mourning.

He also told me something about the musical experiences he had had with his group. From the story I understood that in the past Leonardo had suffered in his role as a drummer. He felt excluded behind the drum set, and had the impression of having to passively adapt to the musical decisions of the other musicians.

When I suggested that we improvise together he agreed with enthusiasm. Leonardo felt capable of playing the guitar while seated on the bed. He asked me to play the violoncello.

In the earlier improvisations I had tried to accompany him in order to facilitate his free expression, creating a musical context in which he could feel himself contained. As occurs at the beginning of many music therapy treatments, Leonardo tended to try as closely as possible to produce what he thought I expected of him. In this third improvisation, on the other hand, he strove to introduce new musical elements, some of which were connected to his experience as a musician.

This new approach became evident toward the end of the improvisation. At the beginning of the sequence the violoncello and the guitar move in a rarified musical dialogue that takes the form of a rhythmical movement over which harmonic and melodic variations are developed. After several measures, an arpeggio of the guitar on the A chord suddenly appears, slightly shifting the start of the measure by a crotchet, making a break with the previous musical order.

The A chord that marks the sudden change in the improvisation is the first chord of the initial arpeggio of the song composed by Leonardo, which became the basis of the last improvisation.

Let's compare this with the arpeggio of Leonardo's song in its complete form, as he played it in the following session.

FIGURE 9.



It is interesting to notice how this arpeggio is varied in the third improvisation. The shift of the beginning of the measure causes a moment of instability in the rhythmic continuity, and this creates a pause and a change in the relationship with the therapist. We can also notice how the first two bars of the arpeggio in the third improvisation follow the harmonic structure of the song, while the third bar, similar to the first, differs from it in the last interval, which instead of a fourth becomes a tritone. Leonardo had waited for the right moment to satisfy his desire to play his song. This desire was accompanied by great tension, since he did not know if and how the Other (the therapist) would have accepted his music. The appearance of the tritone, which once again symbolically as a differentiation in the improvisation, indicates the anxiety filling the patient's expectations (how will the Other see me? What does he want from me?). In the subsequent chromatic scale of the guitar we can sense an

escape, an ascending movement that reaches a different musical space where the violoncello, whose presence is marked by the neutrality of a repeated octave, contains the constellation of the fragmented sounds of the guitar: the harmonics, the material character of the fingered strings, the groups of irregular notes. In a rarefaction bordering on silence, the last four harmonics of the guitar conclude the improvisation.

In this example we can see how, in music, a structure is expressed that relates to an extramusical matrix, regarding the emotional sphere of the patient. This matrix is the source from which the structures of the dream, the symptom, and certain musical forms in free improvisation emerge, always different but always similar in their dynamic. Therefore in this arpeggio declared and immediately denied, the repetition of the suffering contained in Leonardo's story resurfaces ("I can't show my music to the members of my band. I know they wouldn't like it", he told me later). In the music, through the transfer, Leonardo relives the pain connected with the repetition of the experience. In the fragmentation of the last measures we can sense the abandoning of any attempt to comply with the demands of the therapist, and Leonardo's improvisation becomes pure representation of the void.

He commented briefly on this improvisation. He listened to the recording in silence, at times underlining something with his gaze, or murmuring approval for certain musical passages. He thought the last measures were strange, different from what we had played previously. He asked me if I could leave him the recordings of the improvisations so he could listen to them in the days before our next session. Two days later I sent him a CD of the recordings.

When I arrived at his house for the next session the situation had changed. He had been through a terrible night, and the pain was much worse. I asked him if he would rather just listen to some music instead of playing, but he said he wanted to play. I asked him to choose an instrument for the improvisation and he selected the guitar again, asking me to play the lyre. With some difficulty Leonardo sat on the bed and began to play.

He concluded the improvisation with a chord on the guitar, and a soft vocal sound, almost a sigh. When we put the instruments down he smiled at me, satisfied. He told me what I had heard was a song he had written, and that I was the first musician he had ever played it for. He hadn't ever played it for the other members of his group, in the belief that they would not have appreciated it. At the beginning of our encounters the therapeutic relationship had had the function of making the music – the true therapeutic factor – emerge. In this process where the figure of the therapist, deprived of the function of repository of truth, shifts increasingly toward the

background, Leonardo had gradually reached the point of assuming his own subjective truth, starting to recognize the nature of his own desire, symbolically putting his song at the center of the therapeutic discourse, a creative act that ideally placed him on the path of his realization as a subject.

The following week I found him half asleep. He greeted me with a smile. Once again he hadn't slept all night, due to very severe abdominal pain. He was about to fall asleep. He looked at me, smiling, and said, "I wanted to thank you for being with me in this period. I never felt so in tune with another musician before. Without you I never would have been able to let someone else hear my music". I thanked him for the kind words, telling him I would return in a few days. Before leaving, I waited for him to fall asleep.

Two days later I received the phone call telling me that Leonardo had passed away during the night. We can say nothing in the time when this happens, nor can we try to know what function music therapy had in helping him to confront this last moment. We can say that his last weeks were not spent in silence, and that this therapeutic intervention helped him to take one more step along his individual path. At the same time, this consideration tells us something more about our work as music therapists: that as long as life is possible, even to the slightest degree, we have the capability, and perhaps even the duty, to help those who suffer to live that life to the fullest.

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CHAPTER 21

“Petit enfant de son et lumiere”

Gaertner, May

He came into the classroom, stamping his feet and howling furiously. A colleague who'd worked with him privately for a year, went forward to greet him with a friendly smile. He scratched her viciously across her face, leaving four bleeding grooves. This was my introduction to C., an 8 year old boy with autism. It was the first day of the new school year, in a new school, especially created for C and his classmates.

This school was created by desperate parents “pour les enfants en difficultés”, for their children who were different. The parents were desperate because they couldn't find a place for their children. No-one was prepared to take charge of these children. Apart from one or two half-days per week, in a day-hospital, the children languished at home. They had been sent away from care-centres and special schools because of their difficult and often violent behaviour. Their future looked very bleak indeed. Nobody wanted them.

A group of parents formed an association and then set about creating a school for them. There were to be only 8 pupils, and they were composed of children with autism, Down's Syndrome, Brain Trauma, etc.

On the 1st October 2002, Ecole Amethyste opened its doors to these children. The school is housed in 4 rooms, adjoining an ancient Benedictine Abbey which is an historical monument. The enclosed court-yard makes a peaceful playground. The school has a magnificent setting, in the vineyards of Pignan, close to Montpellier, in the South of France.

The first school day flashed by, dragged on, flashed by and dragged on. I was responsible for a small group of children with different disorders. The other person with me at the school was enthusiastic about a Psychology of Movement course which she had followed some years before, and planned to use it with the pupils. Although she was also responsible for a small group, she preferred to work with one pupil at a time, so she simply sent the others to me. She and I were the only adults present, until the cleaning-cooking lady came sometime later.

My many years of experience as a teacher and a music therapist had given me clear ideas of what I wanted to do, what I needed to do. I was going to help these children. I was going to help them learn many useful things, within their limitations and at their own rhythm. I wanted them to feel loved and accepted, to make friends, to have fun, to smile, to laugh. I wanted them to feel, that at last they had a school of their own, that they would not be rejected, that they would never again be sent away, etc., etc.

The first item on my time-table for the day was the Good Morning Ring. I planned to make a circle with everyone joining hands. I'd introduce myself, welcome each child by name and we'd say “Bonjour” to each other. I changed the words of

“The more we are together, together, together.

The more we are together, the happier we'll be” to: -

Nous sommes heureux ensemble, ensemble, ensemble,

Nous sommes heureux ensemble, bonjour mes amis !

Trying to join hands to form a ring proved to be a mammoth task. Smiling encouragingly, holding out my hands and calling out cheerfully eventually brought me a 12 year old boy with Asperger Syndrome. He helped me to include a 13 year old boy with Brain Trauma. Then we managed to encourage two pretty 8 year old girls, one with epilepsy and other problems, and the other with severe mental retardation, to join in. From the time he'd entered the room, C had been howling and stamping his feet. I held out a hand to him, calling his name. He roared, came at me in a fury, and bit me. The children were frightened. I began to sing. C stopped his noise. He

retreated to a corner and listened, periodically moaning and wailing, whilst the rest of us sang, then said “Bonjour”.

I played recordings of classical music and children’s songs. Music consoled and comforted us, drowning some of C’s sounds. It gave us some respite, when he stopped to listen. He quite clearly loved music.

I’d had 5 years’ experience of weekly musical sessions at “Sesame Autism”, a social and recreational centre for children, adolescents and adults with autism. I’d spent Saturday afternoons having music and music therapy sessions with groups and with individuals. Voluntary helpers and parents were there in abundance so I had all the help I needed. The groups were brought to me, and then taken away afterwards to some other activity, by the helpers. I realised that I’d been spoilt. Now I was alone. But I did have music.

What is autism? Paul Cann, Chief Executive of the National Autistic Society wrote: - “Autism is a complex challenge and a potentially devastating disability. Parents and professionals confronting the puzzle (of autism) need help in putting the pieces together.”¹ I certainly needed help and I needed to help.

Autism was first identified by Kanner in 1943. Children with the disorder maintain, very often, extreme social isolation and have a distinctive number of features that set them apart from other children. These features include:

- an inability to relate to others;
- mutism or atypical language;
- insistence on maintaining sameness in the environment;
- rigidly stereotyped play with small objects;
- lack of imagination and playfulness;
- certain isolated areas of ability, such as remote memory, fine motor skills, or special perception;
- normal and attractive physical appearance;
- an onset of infancy.”²

1. Paul Cann : «Introductory Remarks». The Handbook of Autism, Maureen Aarons and Tessa Gittens (Rutledge, London and New York, 1999)

Music therapy is the use of music to bring about positive healing or change. Music has been used in a therapeutic manner for hundreds of years, and it affects each individual in a unique way.

The use of music to influence the human body has been mentioned in writing on Egyptian medical papyri dating back to 1500B.C.³

The Greeks have often been regarded as the forerunners of music therapy, in that they developed both the rational concept of order and harmony, and the limitless ability of music to express feelings and lighten emotional distress, to alleviate disorder.

As a child with autism grows up, the need of some form of adaptation or behavioural modification also grows. Music therapy helps.

- It is important that the child overcomes the obstacles of the disorder and learns how to function in the world. For example, children with autism have the ability to comprehend language though they do not often speak.
- Music therapy is often used to aid in the transition to speaking. It is useful to the person with autism for many reasons, including that, in music, no linguistic barriers exist. In fact, it has been shown that although children with autism do not usually respond to the emotional aspects of speech, they do respond emotionally to music.⁴
- Freud said, in regard to Music therapy, that “we can infer therefore that a musical composition, such as an improvisation, is an acceptable form in which we expose some of our wilder and more out-of-control feelings”.⁵

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2. David L Nelson, Anderson, V.G., Gonzales, A.D., (1984) « Music Activities and Therapy for Children with Autism and Other Pervasive developmental Disorders.” *Journal of Music Therapy* 21 (3) p.100.
 3. Leslie Bunt, *Music Therapy : An Art Beyond Words* (Routledge, London and New York, 1994) p. 10.
 4. Heaton, P., Hermelin, B & L, Pring (1999). Can children with autistic spectrum disorders perceive affect in Music? An experimental investigation. *Psychol. Med.* 29: 1405-10 (Medline).
 5. Leslie Bunt, *Music Therapy : An Art Beyond Words* (Routledge, London and New York, 1994) p. 34

Each of my pupils makes a fascinating study, but I shall concentrate on C, who really is “un enfant de son et lumière”; a child of sound and light.

- **Sound:** because he was and is, always making sounds; angry, furious, anguished sounds; howling, moaning, complaining, scolding sounds; busy, occupied, melodious sounds; happy, chuckling sounds mixed with quiet, peaceful, sighing reflective sounds. He often sings, or bursts out laughing, and that is refreshing music to our ears.
- **Light:** because when he smiles, he lights up the world. I often take photographs which, when enlarged and displayed on the walls of the school, give a pictorial account of the highlights of our life at school, e.g. playing musical instruments, dancing, baking birthday cakes, blowing out the candles, walking in the vines, playing games outside and ... working! Somehow, there appears to be a light shining around C.

So he became our “petit enfant de son et lumière”.

First day: In my report, I wrote: He had a fearful temper tantrum, scratched my colleague and drew blood. He charged at me, grabbed and bit me. Classical music calmed him. Most of the time, he walked around the room, stamping his feet. Eventually, with little percussion instruments, he appeared to bang out his frustration and discontent, until his banging could be changed into a sort of “playing”.

Second day: He chose his corner and settled down on some mats. He wouldn't allow anyone to approach him. He alternated between sitting and twirling a little object at the end of a string, either in complete silence, or making strange, alarming noises, or stamping his way around the room, and howling. He hurt the children. He hurt me. He'd charge like an angry bull. He was actually terrifying.

Third day: He loves music. It calms him. It excites him. He was in a happy mood for most of the morning. He appeared to be pleased to be at school. He played, twirled and sang on his own.

I was inclined to play cassettes most of the time. When he arrived in the morning, the school was filled with music. When I allowed moments of silence to occur, he would push me to the cupboard that housed my music centre, and would tap me until I played the other side or another cassette. CD's were quicker to replay. If I wasn't speedy enough, he'd punch my back very hard.

He often held his hands over his ears. I read somewhere that this meant that he didn't like the music and was trying to shut it out. However, if I sympathetically

stopped the music, he either charged at me in a fury or yelled at me in no uncertain terms. His father, when questioned, answered that it meant he was enjoying the music. I have subsequently read that this is often the case with people with autism.

A few days later, whilst walking in the vines, we heard C singing. He was walking on a wall and singing “le petit musician”, a song on his favourite cassette. He sang perfectly in tune, with un, un, un, un instead of words. I was delighted and sang with him. He jumped off the wall, ran at me and pushed me hard. I understood that he didn’t want me joining in. Then he sang the song again. Later, when he suddenly broke away from the group and raced away, I stopped him in his flight by whistling “Petit Musicien”. He ran to me. I braced myself for the attack, but this time he smiled and hugged me.

The song, “Petit Musicien” was the key to C’s locked doors. It nudged its way into his little isolated world, and lured him out to visit. C was unable to hold a pencil, a crayon or a paint brush. He wouldn’t allow anyone to put something into his hand and would attack us violently if we dared to disturb him. I tried to include him in all the activities and was severely punished for my efforts. It was a good day, if I was only attacked 15 times. Usually it was over 30 times. These attacks included biting, scratching, pinching, punching, kicking, plus his loud, furious noises.

Le Petit Musicien brought about a change. The day after our walk in the vineyards, I played it. He listened, totally enraptured, giving me a chance to sit beside him. I covered a large sheet of cardboard with paper and set it down on the floor beside him. I sang along with the recording and pressed a thick red koki-pen into his right hand. (Later I tried his left hand). Holding his hand and the pen, I helped him to “draw”. We squiggled all over the page. He was so absorbed in the music that he accepted this intrusion. I sang different words, eg. “Bravo C! You are drawing a beautiful picture!” to the tune of Petit Musicien. I changed the colours of the koki-pens and coaxed him to doodle, using big movements. Thus C produced his first work of art before the end of the song – without losing his temper and hurting someone.

I took advantage of this song. The only time C ever co-operated was when he listened to music and particularly to le Petit Musicien. I was able to coax him into holding a paint brush, to dip it into a pot of paint and to paint an “abstract”. His family was delighted with his art-work. This included clay-modelling, sewing, stringing necklaces etc. Naturally his handwork was very primitive and far from perfect, but they were clearly his own efforts.

Twice a week C visited a day-hospital which was an extension of a big teaching hospital. We had a meeting at our school with the excellent team of doctors and therapists who worked with him. They were all pleasantly surprised with the slow but steady improvement in C. At first they couldn't believe that he had actually held a paint-brush and had allowed me to guide his hand, but the photographic display on the walls in the passage, soon convinced them. We, in turn, couldn't believe that C had been persuaded to wear an art overall to protect his clothes. The team was surprised – no problems had ever arisen. However, as we always had a fierce temper tantrum and someone got hurt, we didn't insist. His parents didn't mind the paint on his clothes. We didn't have art-overalls – we used his Dad's old T-shirts. The therapists laughed and said, "We have his clothes protected but he refuses to paint. You cannot get him to put on an overall but you have him painting!"

The following day I planned a painting session. Whilst the children put big T-shirts over their clothes, I sang and danced with C. I stood behind with my arms around him. I knew that I was inviting an attack, so I had to protect myself. I improvised, something like this: -

"I know, I know, Alain told me so.

You wear a T-shirt at Villa St Georges,

So don't you say "NO!"

I know, I know, it's very, very clear,

You're playing with us, you're playing with us,

Oh dearie, dear, dear!"

The other children took this up, and whilst we were clowning around, I was able to slip the T-shirt over C's head. We were laughing, singing and dancing, and miracle of miracles, he kept the T-shirt on ! Thereafter, he wore a T-shirt for painting. If ever he resisted, we sang, danced and laughed, and we never had a problem. He got the message.

As R.Benenzon wrote: "Music Therapy is a para-medical discipline which uses sound, music and movement, to open the canals of communication."⁶

6. Benenzon R., *Manuel de musicothérapie*, Privat. Paris, 1977, p. 13.

Thaut wrote: “For persons with autism, music therapy can interrupt patterns of isolation and social withdrawal and enhance socio-emotional development. Characteristics of this impaired socio-emotional functioning can include:

- lack of eye contact
- lack of physical responsiveness
- aloofness
- lack of peer relation
- often obsessive preoccupation with objects
- -maintenance of environmental sameness.

While these may change in intensity as the individual matures, social aloneness remains.⁷

Breaking the pattern of isolation and engaging the child with autism in external rather than internal activities and relationships, can prove central to addressing other cognitive and perceptual problems.

I was not employed as a music therapist but as a specialist teacher. As I was responsible for a group of children all day of every school day, I was unable to take C individually for music therapy. However, I was able to turn the situation to his advantage, and also to the advantage of each child. We had a lot of music of many kinds. Musical sessions were often initiated by the children. Most of them couldn't talk but they showed me what they wanted, eg. they would push me to the music centre and say “Musique, musique, oui?” “Oui!” or they would take the box of instruments from the cupboard and with excited enquiring smiles ask “Oui? Oui?” Sometimes we'd play and sing, eg. Frère Jacques, or they would accompany the recorded music. Sometimes, I strummed my ukulele whilst they played the little percussion instruments. Each child would have a turn to strum the strings of my ukelele and we'd sing. Very often, as some were hyper-active and needed to move, they either marched around the room playing their instruments or they put instruments away and danced. It was moving to see a child helping another child. C was often given an instrument to hold, then one of his hands was grabbed and he was shown how to play it. At the beginning he would hit his classmate and throw the instrument across the room.

7. Thaut, M.H. A Music Therapy treatment model for autistic children. *Music Therapy Perspectives*, 1 (4), 7-13 (1984).

Here are some reports of the 4th month at school.

1ST WEEK

Passed happily on the whole. There was an improvement in holding a pencil, crayon, Koki pen and paint-brush. However, he destroyed everything he could lay his hands on. He tore down the paintings and drawings of his classmates from the walls. He broke up objects which they had made, eg. their necklaces and clay animals. Heard the children hastily singing *Petit Musicien* to calm him, whilst trying to rescue their belongings.

2ND WEEK

He drew a picture seated at a table. He cut up coloured straws and threaded the little rings to make a necklace. Later, could do nothing with him. He destroyed everything he could lay his hands on. As usual, he refused to go out. Once outside, he kept creeping back into the classroom to turn the place upside down. He was very violent. Often crept up behind my colleagues, and more often me, to smack, pinch, punch and kick us. He was very, very difficult indeed.

3RD WEEK

Monday: He was very difficult but then I discovered that he loved mandarins, so with one segment at a time, I persuaded him to dance, to draw, to cut straws, to thread the little rings onto a string. Seated at a table, he did “un dessin à deux” with a little classmate. It was a great success. He returned to the straw-cutting and threading a necklace repeatedly during the day, for quite long periods.

Tuesday: He arrived at school in a happy mood. For the first time, without a temper tantrum, he copied me, when I changed from outdoor to indoor shoes, and arranged them in the passage – all on his own. He was very affectionate. He drew a colourful abstract. He played some instruments.

Wednesday: No school.

Thursday: He listened to classical music for a long period. He sang and danced. He helped the other children to do a floor puzzle. He fitted in the letters C Z K O on his own.

Friday: He listened to classical music. He played some instruments. He sang and he danced. He cut straws, threaded the little rings and made a necklace. He pulled it apart. He did the floor puzzle with the others. He played with the pâte-à-sel. Was

happy and peaceful for at least 30 minutes. Often ate large pieces of it, and laughed when we made exaggerated, protesting noises.

He played outside with a rope, with the other children. Had him alone for a session of music therapy. He smiled and smiled.

R. Benenzon wrote that “to be able to establish a contact with another being, or to open some channel of communication, it would appear necessary to imitate the other, to do something similar.”⁸

So the following time that C stormed at me with a roar, I roared back. He and I roared at each other. A look of surprise crossed his face, and a little of the fury left him. I imitated every noise he made, somehow changing it ever so slightly in volume and intensity. I began to strum my ukelele, and eventually our roaring and shouting and yelling changed to singing loudly, then to singing gently and finally to sighing with satisfaction. His anger was spent.

Sometimes, imitation meant stamping feet. Finally all the stamping, rhythmic shouting and the singing, released his anger and frustration. The stamping changed to dancing. The anger changed to laughter.

C had no medication. His parents shared my belief in the Dr Bach Flower Remedies. They supplied a bottle of the Rescue Remedy and gave me written permission to use it. By the end of the school year (June 2003), thanks to the Rescue Remedy, the hard work of the day-hospital staff, our school and very especially music, things were very different indeed.

The school reopened for the 2nd year in September 2003, and we often say that C is the best behaved child in the school. We look at him and simply cannot believe that he is the same child.

The school is still hopelessly understaffed and very poor financially, but it is so rich in many other ways. We now have four excellent students, who initially came to do their practical training with us, and who have continued coming as devoted voluntary workers. It’s a happy school where each child feels loved.

Sesame Autism has lent me its “roue musicale”, a musical wheel and a large box of chimes. The musical wheel is a percussion instrument made of metal, wood and

8. Benenzon R., *Manuel de musicothérapie*, Privat. Paris, 1977.

skin. It is round and was created with group games in mind. It is like a table with 5-6 people around it, and as soon as it is set up, one hears the tinkling of the chimes which are arranged around the wheel, or the beating of sticks on the drum centre.⁹ With the musical wheel, the children converse and communicate, dialogue and debate, non verbally.

Some years ago, Tim Swingler of the SoundBeam Project in England, lent me a Sound Beam, which I used for Alzheimer patients and for the children of Sesame Autism.

Some of the children, in their most unreachable moods, were lured out of themselves by the SoundBeam. When the invisible beam was interrupted somewhere along its signal, it sent out a message to a MIDI module, which had been programmed to play musical sounds of varying pitch and intensity, according to the depth of the interruption. Little by little, the children began to understand that they had something to do with the sounds they could hear. When they kept still, silence prevailed. When they moved, they heard sounds. Some of them realised that they had the power to produce sounds, to create and to control something. The wonder and the joy of this realization filled them with a radiance, and peace.

With these memories in mind, I would very much like to bring SoundBeam to the children at Ecole Amethyste; I strongly feel that SoundBeam would be an important step forward in their development. It would certainly help C.

Alvin suggests that learning to play wind instruments is in many ways equivalent to learning to make speech vocalizations. It can strengthen awareness and functional use of lips, tongue, jaws and teeth.

Alvin also points out how music can serve as an important link between parent and child, providing a channel of communication, and a model of how both parties can relate to each other.¹⁰

The school has been given a dozen recorders, which I'll introduce to the children very soon.

9. Rivemale C.: "La Roue Tourne" Mémoire DU de Musicothérapie, Montpellier, 1994.

10. Alvin J.: Music Therapy for the Autistic Child. London. Oxford University Press.

The school closes for the long summer holidays at the end of June. C has not been involved in any incidences of violence, nor of destructive behaviour. He was on a gluten free diet, and is now avoiding all dairy products. We continue to work closely with the staff at the day-hospital. From time to time he has a drop of Rescue Remedy in a little water. The phenomenal change in “notre petit enfant de son et lumière” is largely due to Music and Musictherapy.

CHAPTER 22

*“Meaning” in music
therapy*

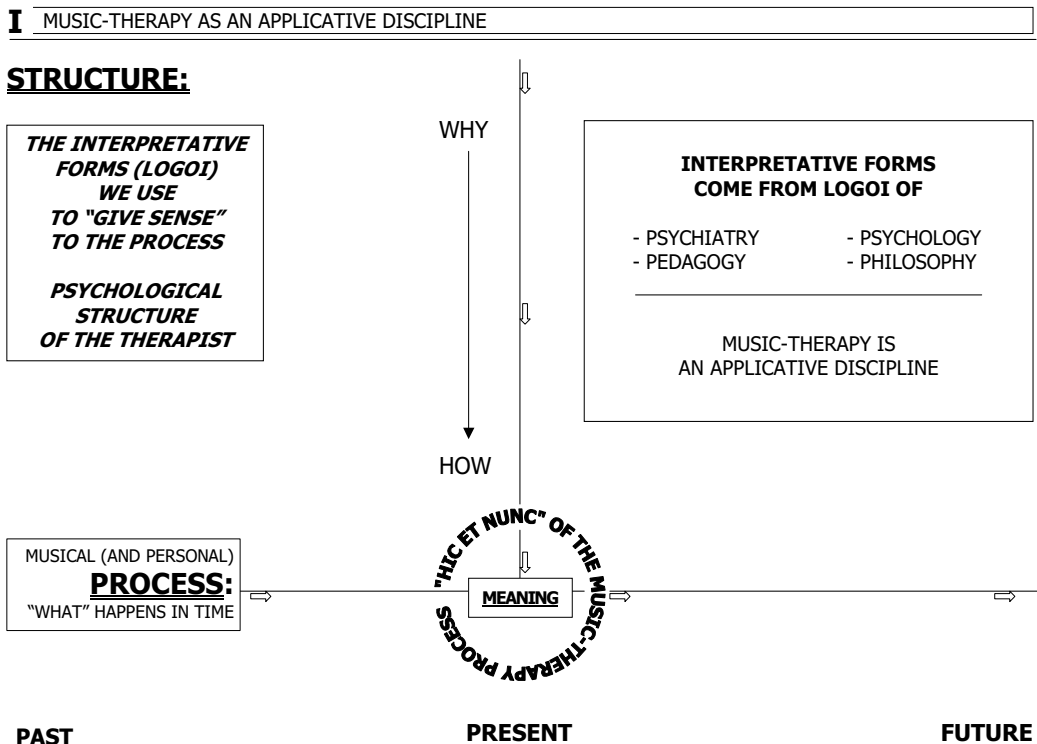
**Critical reflections about the
epistemological statute of the discipline,
about the options present in the
contemporary panorama and the most
diffused training models**

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FIGURE 1.



Whoever wonders what music therapy is may, in my opinion, look for an answer in two different ways.

The first one is the *historical description* of what the human activity called ‘music therapy’ has been and how it has developed up to now in different countries and in the most various applications.

I think that, in agreement with this a perspective, music therapy can be defined as a manifold process which gradually has led it to being conceived and carried out according to many different needs and concepts.

The second way is to ask oneself the following questions: by what forms of reasoning am I able to conceive something that can be defined as ‘music therapy’?

In which sense is it possible, according to such thought paths, to speak about ‘meaning’ in music therapy¹?

In this paper, by choosing the second way, I shall briefly present what, in my opinion, the two basic conceptual approaches to this subject in the contemporary panorama of music therapy are.

In this way I’ll try to offer some instruments helping in the development of a critical consciousness of the epistemological foundations of the discipline and which, at the same time, can illustrate the different proposals deriving from the positions assumed toward these foundations in training practice.

Moreover, I shall try to indicate the main lines of a third way I have been inquiring into for some years, also availing myself of the opportunities of reflection I have found experiencing cooperation and exchange of views with my colleagues of ‘MusicSpace Italy’.

I think it is possible to accept, at least as a *starting point* of our reflection, the assumption that, when speaking of music therapy, one generally refers to some kind of use of sound and music aimed at promoting the development and health of human beings through the manifold strategies by which it is possible to do so. The most important of these are: therapy, rehabilitation, education, personal development and, more generally, all the ways in which the so called *helping relationship* is carried out.

I propose to define ‘sound therapy’, and not ‘music therapy’, as all those activities consisting in the application or employment of sounds or music aimed at reducing specific symptoms or states of suffering.

1. About the problem of ‘meaning’ in music therapy see the articles appeared in the *Nordic Journal of Music Therapy*, starting from the issues of 2000, particularly K. Bruscia’s (interviewed by Bryniulf Stige), “The Nature of Meaning in Music Therapy”, in *Nordic Journal of Music Therapy*, vol. 2, IX, 2000.

After having made this previous distinction, all the kinds of activities we refer to when we speak of ‘music therapy’ are forms of *relationship* in which the presence of the *musical element* is required.

All forms of music therapy include musical experiences, such as performances, improvisations, listening experiences. Such experiences, as well as the related physical, emotional, affective, cognitive, behavioural reactions, develop during each session and throughout the complete set of sessions which make up the whole music therapy relationship. In other words all these experiences and the related reactions develop in *time*.

I propose to call this temporal development² *process*.

However, all the different and varying musical, extra-musical, physical, emotional, affective, cognitive and behavioural events taking place during the whole process, can be identified, interpreted and understood only if connected with a core of conceptual contents that must keep at least a certain level of stability. I propose to call this core of quite steady conceptual contents *structure*.

In every kind of human relationship there are *process* elements (that is to say, *what happens during the time* in which the very relationship takes place), and *structural* elements (consisting of the psychological and cultural factors through which we *give a sense to the process*, in other words, through which we *interpret* it).

Whilst in a ‘normal’ relationship the structural factors can function ‘automatically’, without us necessarily being aware of them, a *professional* relationship is first of all marked out by the level of consciousness the professional therapist has of the structural elements he is placing at his patient’s disposal while performing the *function* typical of his *role*.

In the case of music therapy, we can observe that the *process* includes *musical* experiences and, in a more general sense, the *relationship* between the music therapist and his client, while the *structural* elements are the factors according to which the *process* is chosen, planned, led, judged, concluded, interrupted or carried on³.

But what are the *structural* elements in music therapy?

2. About the notions of ‘process’, ‘structure’, ‘role’ and ‘function’ cf. S. Erba, *Domanda e risposta. Per un’etica e una politica della psicoanalisi*, Franco Angeli, Milano, 1998.

Many take the view, which characterises the *first of the options*⁴ outlined here, that they basically depend on the adopted *psychological* (or *psychiatric*, or *pedagogical*, or *philosophical*⁵) *model of reference*, as well as on the idea of *role* deriving from it.

According to some psychological models (mainly, but not exclusively, the psychodynamically oriented ones), the therapist should possess a further structural element: consciousness of his own psychological balance and of the related defensive structure. Therefore an integral part of his training consists in a process of development of his personal consciousness (for example, a proper ‘personal analysis’, eventually followed by ‘didactical analysis’).

From this point of view ‘music therapy models’ should be considered as ‘operative models’, since they indicate *how* the *process* must be. But to understand *why* it should be considered that way it is necessary to refer to an ambit of developed knowledge (to be searched for within the disciplines we defined as ‘interpretive *logoi*’) *connected with* but *external to* the specific (application) area of music therapy. From this perspective it is possible to speak about a music therapy *event*, but not of music therapy *meaning*; *meaning* (which is the *structural* element, the dimension of *why*) is always to be found in an interpretive discipline external to music therapy, while the specific sphere of this discipline concerns *how* the *process* is carried out on a operative level.

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3. 3 All this must obviously be constantly compared with what is usually called ‘clinical evidence’ – which, on the other hand, is both an important and a complicated notion. In fact, if on one side it is possible to notice an ineludible –and, in a sense, ‘ultimate’ evidential dimension in it, on the other hand we cannot avoid observing that the very interpretive (and diagnostic) models we use to ‘read’ the human suffering, especially the psychical one, somewhat ‘create’ themselves (psycho)pathologies.
 4. I am aware that the music therapy models really present in contemporary society do not reflect the options described here in a ‘pure’ way. However, I think that models like the ones proposed, for example, by Benenzon or Priestley, can be included in the first option, whilst the Nordoff – Robbins’s and Alvin’s models can be reasonably included in the second one. Apart from this, one of the aims of the present paper is to make clearer some aspects which are present (and sometimes coexistent) within the different approaches to music therapy.
 5. From now on we shall refer to this group of disciplines upon which the ‘frames of reference’ are usually based using the expression ‘interpretive *logoi*’.

Thus it is clear that a music therapist, who wants to carry out his clinical work with sufficient *autonomy*, should possess adequate skills both about *how* (where the word is meant in a music therapy, and then ‘technical’ sense) and about *why* (meant in an ‘interpretive’ sense).

But in case the operator, during his training, had not adequately taken care of and pursued the aim of developing his ‘interpretive competence’, his clinical work should be necessarily carried out on the responsibility and under the supervision of a specialist in *why*, who possesses interpretive competence suitable for the process which is activated and the aims which are pursued⁶.

Furthermore, in accordance with such a way of thinking, it would be necessary to distinguish between a classic (and then interpretive) ‘supervision’ and a *technical* one, which could also be carried out by a specialist of the *how*.

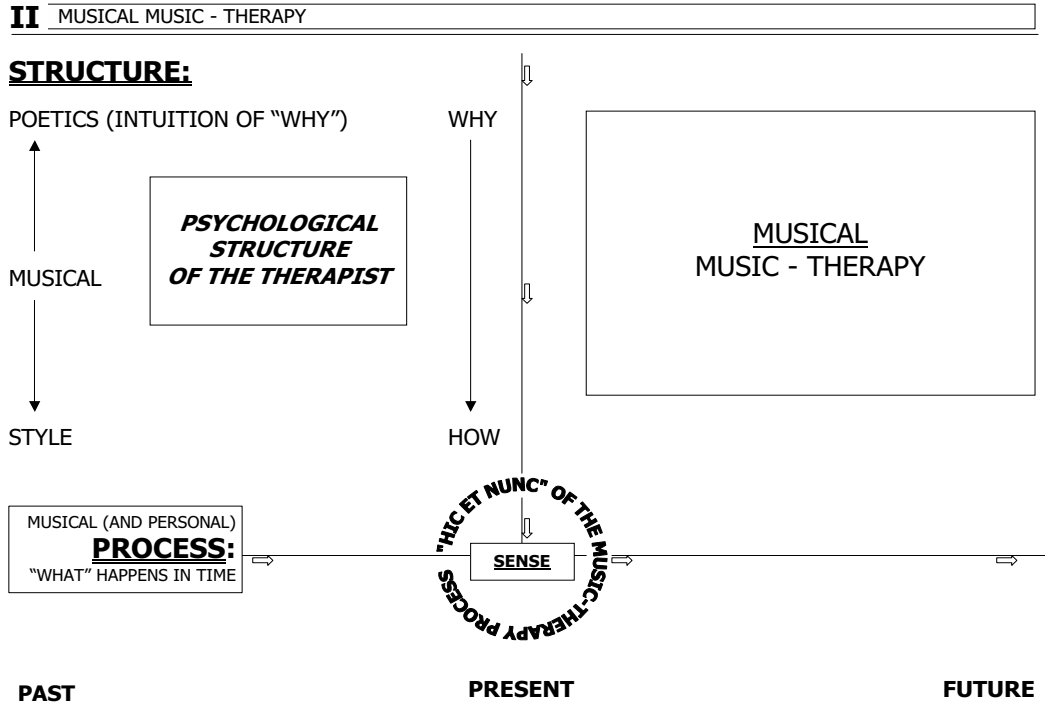
This first option offers the advantage of being absolutely firm-ground from both a theoretical and a methodological point of view, of being historically well-established and of clearly identifying everyone’s roles, spheres of competence, responsibilities.

On the other hand it involves the danger of relegating *music* (which many authors consider, in my opinion correctly, to be a basic dimension in music therapy) to a condition of real inferiority, or even of irrelevance, to the *logoi* which express the ‘interpretive frames of reference’

In this perspective in fact *music* is recognised to be a significant element only if it is *translated* into another language (psychological, psycho-therapeutic, etc.), basically different from *itself*, so that a great deal of its essence (that is, of the specific *musical dimension*) inevitably gets lost.

6. Supervision is a professional service to which *all* therapists, regardless of which option they refer to, should resort to, as a guarantee of the quality of their clinical work and to support their own growth and professional maturity. Apart from that, in the present case I should like to point out that the *clinical responsibility* for the therapeutic process should be taken by a specialist who possesses an adequate ‘interpretive *logos*’.

FIGURE 2.



Let us examine now the *second option*.

While for the first one it is possible to speak about (operative) music therapy models either based, for instance, upon a *psycho-dynamic*, *humanistic*, *cognitive-behavioural* approach, or referring to *PNL* or to any of the other interpretive *logoi*, I suggest we should call the second option *musically-oriented* music therapy.

According to this different concept, the music therapist should first of all be a *musician*, not only 'someone provided with musical skills', but a musician who, apart from the musical genre he refers to, has been able to achieve true *interpretative quality* through his musical practice.

In this perspective, musical experience represents the ‘opportunity context’ in which what we called *process* develops, and also the *how* thanks to which the communication between the music therapist and his partner takes place.

When interpreting a piece a musician is supported both by an instrumental (or vocal) *technique* and by an interpretive *style* that ensure him the chance of penetrating and ‘inhabiting’ the *how* dimension; on the other hand *style*, in its turn, gives expression to a kind of *poetics* which, on the whole, allows the interpreter to orientate in the dimension of the *why*.

Poetics in fact can be defined as the set of conscious and unconscious ‘value guidelines’ that constantly lead us in our stylistic and, more generally speaking, expressive choices.

However, it is important to point out that for a musician (as well as for any artist) the *why* dimension, which is the basis of his interpretation, can be grasped essentially through *intuition*.

If the ‘*why*’ we reach thanks to one of those we defined *interpretive disciplines* or *logoi* reveals (or rather, it *should* reveal) through a consistent and clearly structured reasoning, the ‘*why*’ we gained ‘artistically’ is fundamentally an *intuitive why*.

However, if a musician usually pursues *aesthetic* goals, a music therapist should mainly aim at (and be responsible for) some kind of *care*⁷.

Style and poetics which come from an “acting out” dimension (that is to say, testifying to an essentially ‘projective’ *intuitive why*), if supported by artistic talent, can anyway lead to appreciable artistic results, on a clinical level and in all the situations that aim at creating a *genuine* contact with the Other, the same style and poetics turn out to be inadequate.

That is why a music therapist, especially if he refers to this second option, should be really ‘adult’, that is to have reached a true psychological maturity, which allows him to meet the Other in music through non-mystifying and non-‘projective’ attitudes⁸.

7. In saying so I absolutely do not intend to minimise what in my opinion is the real, even though indirect, responsibility of the musician: in fact with his work he greatly contributes to giving shape to the aesthetic and ethical sensibility of the individuals and of the society, even apart from his personal intentions and motivations.

Structural elements are guaranteed here by the therapist's poetics and by his profile of personality.

A *training* which aims at forming new therapists according to the aforesaid perspective, should pay special attention to those stages of training which are specifically directed to make students as aware as possible of such *structural* aspects.

Of course, to keep the highest consistency of inspiration, such 'paths towards awareness' should basically be 'musical paths'.

In this kind of music therapy, both the *how* and the *why* dimension essentially consist in *music*.

Thus music therapy becomes an *autonomous*, and not merely *operative*, discipline, or rather, by changing the form, but not the substance of the concept, can be considered as a *therapeutic application of music*.

In other words, the greatest merit of this 'art beyond words'⁹ is that only thanks to it can one speak about *music as a therapy*¹⁰.

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8. This need is obviously common to all music therapists (and not only to them), whatever the orientation of their work is. Yet, while for those who choose the first option the actual possession of an 'interpretive logos' must (or at least should) imply an adequate level of consciousness (also because language, by its own nature, makes it easier the inter-subjective control processes), in the second case intuition, which orientates one's actions belongs to a basically 'ineffable' sphere. In such a context, a therapist's *natural* (where *natural* means 'not directly depending on the possession of an interpretive model acquired through specific training') personal maturity is the best guarantee of the quality of his work. Otherwise how could we distinguish between, for example, a condition of 'fusional empathy' – in which the Other is perceived as a part of us and as significant only on condition that he 'can-is disposed to-wants to' meet our *needs*- from a condition of 'adult empathy'- in which the Other is recognised and perceived as significant *because* we recognise his 'alterity' and his difference, upon which his (and our) freedom and self-determination are based? (cf. G. Gaggero, "La musicoterapia nei processi clinici ed educativi" in *Musicoterapia nella Relazione Educativa e Terapeutica. Atti del Corso di Formazione per Docenti della Provincia di Parma*, Parma 2004.)
 9. This definition, which clearly refers to Leslie Bunt's well-known book (*Music Therapy. An Art Beyond Words*, Routledge, London, 1994), very effectively represents a theoretical orientation which not only can be included, I think, in the option described here, but, in my opinion, also exemplarily testifies to it, increasing its prestige and credibility thanks to its positive confirmations in clinical experience.

On the other hand, one of the greatest difficulties in this approach consists, on a theoretical level, in its ineludible dimension of ‘ineffability’, which can give rise to some problematical aspects, for instance in supervision, and, more generally, in the sphere of interdisciplinary communication.

In the training courses inspired by these guidelines, the ‘musical’ quality and the artistic competence of the trainees should be the highest possible, and it should be possible to define clearly, through an organic vision, the standards according to which both their *personal* and *musical* growth and maturation should be valued (as for self-consciousness and the awareness of their *style* and musical *poetics*).

The achievement of an adequate personal maturity (or adulthood) is of the greatest importance in this context, since it represents the main guarantee that the musically guessed *why* (that is, the most relevant *structural* element leading the clinical process) is not conditioned too much by ‘projective’ factors, apart from the aesthetic quality the student is able to express in *music*.

It would also be necessary to determine which kind of relationship has to be maintained with ‘interpretive *logoi*’: in such a context, in fact, they unavoidably play an ancillary role, which can involve other difficulties as far as training is concerned.

For instance, this relationship can be lived in quite an ambivalent way: in fact the *why* revealed by the ‘interpretive *logoi*’ can be felt as useful, but at the same time as non-essential, since it does not concur in defining the peculiar essence of music therapy (in other words, it can be perceived as unessential). On the contrary, the *why* testified to by musical intuition, which is obviously felt as essential, turns out to be fundamentally incommunicable by means of conceptual language.

Of course this reveals how difficult such an approach can be from an epistemic point of view.

Finally, a professional trained in this manner can find it particularly difficult to identify his specific ‘role’.

In fact he who refers to the first option described, immediately sees his place in the hierarchy of the different kinds of knowledge, since he knows whether he is (or is

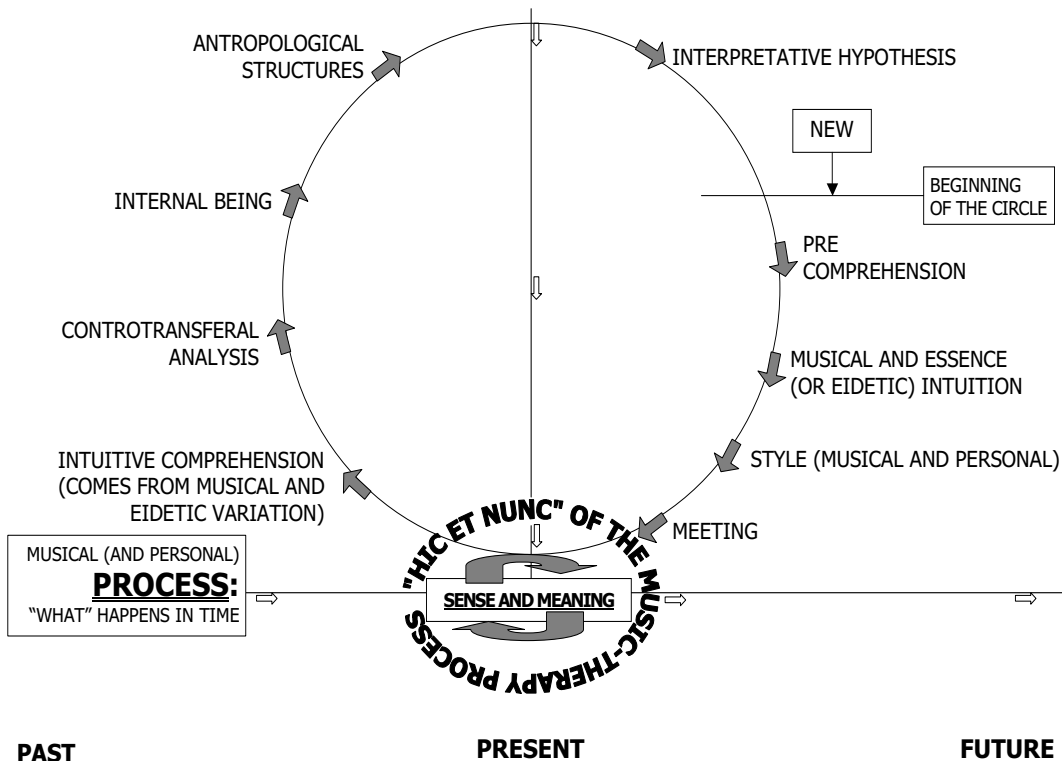
10. Cf. K. Bruscia, *Defining Music Therapy*, Barcelona Publishers 1989.

not) competent as for a *why* socially recognised as related to the care of health (or to educational processes).

He who follows the second perspective, instead, *feels* on one hand that the way he acts (supported by the actual intuition of a *why*) is irreducible to a merely *technical* acting, which is normally accepted by the specialists in *how* operating in the first perspective); on the other hand, he bases his professionalism upon a kind of 'knowledge' that, because of its method (intuition) and its contents (music), is not usually included among the 'interpretive *logoi*' which are traditionally recognised as providing the responsibility (and therefore also the 'power') for orientating clinical or 'curative' processes.

FIGURE 3.

III PHENOMENOLOGICAL-EXISTENTIAL MUSIC - THERAPY (THE HERMENEUTIC CIRCLE IN MUSIC-THERAPY)



As we have just seen, the two described perspectives have both positive and problematic aspects.

On the other hand, I agree with Postacchini and Ricciotti when they say that in music therapy -and not only in it- "many theoretical frameworks are often much weaker than the practical results obtained from their application"¹¹.

As for me, I think that the very core of music therapy work is the dimension of *listening* (*listening as a therapy*); this assumption is the starting point which can give rise to the guidelines of a *third option*.

Actually I don't believe that all forms of *music* are a 'child' of *listening*. By music, as in all kinds of human communication, one can express *projective* and *acting out* dimensions as well as a *genuine listening* of oneself and of the Other.

From such *listening* both verbal-conceptual *testimonies* (that is to say, coherently structured by means of *meanings*), and *testimonies* which can be defined as *non-verbal representations of sense* can arise.

True *listening* can be realized only in the light of a *sense*.

I call *sense* (in the singular by definition) the affective-emotional-cognitive intuition of the totality or wholeness¹².

By this I do not mean to state that something which can be defined as 'wholeness' or 'totality' really exists: this is an ontological question pertaining to philosophy. What I really mean is that, when the individual's intentionality opens up, this unavoidably entails an intuitive representation of the idea of totality, and this idea affects our opening onto the world from an emotional, affective and cognitive point of view.¹³

In other words, one can say that *sense* is not a *meaning* but makes up the 'light' by which each meaning reveals its affective, emotional and symbolic aspects.

11. See P.L. Postacchini and A. Ricciotti, "Dialogo riabilitativo fra Musicoterapia e l'età evolutiva" in *Musica et terapia*, n. 8, 2003, p. 11. Obviously, this opinion stimulates a more profound investigation into the presence, connotation and relevance of the so called 'non-specific factors' in therapy.

12. For a more detailed treatment of the concepts of 'sense', meaning', 'style' and 'narration' in music therapy see G. Gaggero, *Esperienza musicale e musicoterapia*, Mimesis, Milano, 2003

13. Both the phenomenological-existential and the humanistic psychology have thoroughly explored this subject, especially concerning its emotional-affective connotations, while the Gestalt psychology has investigated the aspects of it more closely connected with the cognitive dimension.

On the contrary *meanings* (in the plural by definition) define, more or less unequivocally, single objects or, at least, specific portions of reality.

Denotative meanings (in which a conceptual content links up unequivocally to a *referent* through a *signifier*) are usually distinguished from *connotative meanings* (in which the *signifier* refers to symbolic, suggestive and emotional elements that go beyond denotative univocity and, after all, allude to a *sense* dimension)¹⁴; from now on, by *meaning* we shall refer to the *connotative* value of the word.

Therefore one could speak about a kind of communication based on a sort of *sense symbolism* (including non-linguistic and non-conceptual forms of art, such as music, dance or the figurative arts, especially in their ‘informal’ versions); we have also to point out the existence of a *meaning symbolism* (including *verbal* forms of art, such as poetry or theatre); in the end, we have to consider a kind of *hermeneutics* able to draw out the possible sense dimensions and meaning articulations hiding in such symbolic contexts.

The first one is able to generate a form of *sense/sense* communication; the second and the third can give rise to communicative processes based upon *meaning/meaning*, *meaning/sense*, *sense/meaning* movements.

I define the flowing in time of a story (musical or not) as *narration*: it represents the ‘diachronic’ articulation of *sense* which shows dynamically through symbolic representations of *sense* (as happens in music) or of *meanings* (as in verbal forms of communication).

I call *style* the structural component of the story that, moment by moment, ‘synchronically’, reveals to us the ‘how’ of *narration*.

Of course there is no *style* (which ensures *sense* from a ‘synchronic’ or ‘vertical’ point of view) that does not become ‘historical’ through a *narration* (which is the articulation of *sense* in a historical, ‘diachronic’ and ‘horizontal’ dimension¹⁵).

One could say that *style* is a testimony of *sense* and *personal identity* in the ‘here and now’ (*hic et nunc*), as, by expressing one person’s unconscious ‘poetics’, it represents those emotional, affective and cognitive ‘evidences’ and those ‘values’ in relation to which every kind of *narration* is articulated and developed.

14. Cf. R. Barthes, *Elementi di semiologia*, Einaudi, Torino, 1983

At this point we can observe that there are some kinds of reasoning which assume as their specific subject the sphere of *being* in its indissoluble bond with *sense* (and therefore with *listening*); thus they turn out to be interpretive methods particularly suitable to promote a fruitful movement *sense/meaning* and *meaning/sense* in the concrete (and therefore also clinical) field.

Such forms of reasoning belong to ‘philosophy’ (in fact philosophy is that kind of *logos* which assumes *being* as such - that is to say the *whole* – as its specific subject). Among the different ‘philosophies’, ‘phenomenology’ and ‘hermeneutics’ (which is both historically and theoretically connected with phenomenology) are the ones who have more radically investigated themes such as *intentionality*, *lived experience*, *intuition*, *empathy*, the formation of *inter-subjectivity*¹⁶, and have also related to one another the spheres of *being*, *whole*, *interpretation*, *symbolism*, *listening* and *authenticity*.

That is why these philosophical trends have been chosen by many psychiatrists, as well as by many psycho - therapists¹⁷, as theoretical references able to orientate them into the interpretation and cure of mental illnesses, and of all kinds of human suffering which are characterised by the difficulty, or even by the impossibility, to express a *sense* one can recognise himself in.

15. What I have just stated can suggest a different way of reading what Mercedes Pavlicevic called ‘Dynamic Form’. (Cf. M. Pavlicevic, *Music Therapy in Context. Music, Meaning and Relationship*, Jessica Kingsley Publishers, London, 2002). This author writes: “Musical interaction displays reveal the *communicative* quality of the interaction and, conversely, **non-musical** acts such as gestures, movements, vocalisations and movements reveal musical, interactive features”(p. 130); this is due to a ‘dynamic form’ which puts the musical dimension in touch with the emotional one; the features of this ‘dynamic form’ “are not purely musical, but then neither are they purely emotional” (p. 131). This concept, in my opinion, can be usefully compared with the following one: *style* (musical or not), in its flowing through a *narration* (musical or not), testifies to its *sense*, to its ‘communicative quality’. *Style* is the way (the *how*) which, by means of experience, testifies to the *primary* (emotional, affective, cognitive) *evidences* which build up the foundations of our identity. Thanks to such *evidences*, it is moulded what Luigi Pareyson defined “**shaping shape (forma formante)**”: it consists in *style*, that essential identity ‘shape’ which, meeting the contents of the existential *narration* in its dynamical flowing in time, turns out to be a ‘shaping’ structure, able to give unity, breath and sense to the narration itself. (About the idea of “shaping shape” in aesthetics and philosophy see L. Pareyson, *Estetica. Teoria della formatività*, Bompiani, Milano, 1988, p. 75; for its adaptation to music therapy see G. Gaggero, *Esperienza musicale e musicoterapia*, op. cit., pp 36-40).

There is a philosophical concept which is especially relevant to our subject: the idea of the *hermeneutic circle*. Firstly formulated by Heidegger¹⁸, it was subsequently developed by Hans Georg Gadamer¹⁹, and its importance in terms of clinical application clearly results from the rich literature produced by phenomenological and anthrop-analytic psychiatry and psychopathology²⁰.

According to this suggestion the process of knowledge develops by means of a continuous *circular* movement between two different modes of approaching the Other: the first is a *noetic-intuitional-synthetic* one, by which I can prefigure the whole *sense* of the object, text or person I enter into relations with - as well as of the relationship itself -; the second, a *dianoetic-analytical-discursive* one, shows the *meanings* which connote, on different levels and according to different perspectives (the ‘categorical’ and the ‘ontic-clinical’ one), the *object*, text or person I am related to, as well as the relationship itself.

In this *circular* movement, *intuition* is the dimension of *sense* which founds and sets *meanings* in a coherent context, while the conceptual articulation of *meanings* allows the tracing of new perspectives, ‘lands’ and ‘dimensions’ in which and by which *sense* can show itself.

The *comprehension* of the Other (which is also, unavoidably, self-comprehension) therefore results from the mutual enlightening and *verifying* of these two moments.

16. As for these last two themes, it is of the greatest relevance to point out the contribution given by Edith Stein’s way of thinking. Especially her thesis according to which *empathy* is the real foundation of *inter-subjectivity*, in my opinion, is still to have a serious impact on the theoretical reflection of those who deal with relational therapies (music therapy included), as well as of philosophers (cf. E. Stein, *Empatia*, Franco Angeli, Milano, 1985).

17. Obviously, here I am referring to the rich and complex movement made up by phenomenological and anthrop-analytical psychiatry, psychology and psychopathology, whose most significant representatives were Karl Jaspers, Ludwig Binswanger, Eugene Minkowski, and which also in Italy had and still has outstanding exponents, such as Arnaldo Ballerini, Eugenio Borgna, Bruno Callieri, Danilo Cargnello and others.

18. Cf. M. Heidegger, *Essere e tempo*, Utet, Torino, 1978

19. Cf. H. G. Gadamer, *Verità e metodo* (1960), Bompiani, Milano, 1983

20. About this see A. Ballerini, *Patologia di un eremitaggio. Uno studio sull’autismo schizofrenico*, Boringhieri, Torino, 2002

Anthrop-phenomenological psychopathology has identified in *essence intuition* (also called *eidetic intuition*) and in the perception of its tuning and varying in time (*eidetic variation*)²¹ the basic instruments which allow the first moment of the *hermeneutic circle* to develop.

(We must also remember that, after Heidegger reformulated Husserl's notion of *intentionality* as *care*, *eidetic intuition* and its *variation* – originally connoted only from a logical point of view – can be seen –as I think too- as including also the affective-emotional dimension).

The same line of thinking identifies in *reflection* the modality by which the second moment takes shape.

Such *reflection* –as Ballerini clearly pointed out-²², consists of two different *phenomenological* perspectives:

- a *subjective* one (as meant by Jaspers), aimed at the understanding of the individual *lived experiences*; such understanding can start from an *encounter* with the Other taking place in a *dialogical* and *empathic* dimension (but this empathy – it is better to specify that- must be an *adult* and not a *fusional* one²³);
- an *objective* one (as meant by Husserl, Heidegger and Binswanger), directed to investigating and understanding the specific 'hairline cracks' which characterise the categorial (or 'transcendental') structure of Presence and are the foundation of its specific way of *being-in-the-world*; all this, as we have already said, relies on a cognitive experience based upon *eidetic intuition* and in its *variation*.

In a similar way, I propose to consider music therapeutic work as a *circular* process in which, by meeting the Other in a *musical* dimension, it is possible to get a sort of *intuitive* pre-comprehension of Him as a whole, an encounter with his *sense* dimension; such pre-comprehension can be realised during shared musical experiences, thanks to specific *stylistic* and *narrative modulations* and to the corresponding *eidetic variations*.

21. Cf. E. Husserl, *Idee per una fenomenologia pura e per una filosofia fenomenologica*, Einaudi, Torino, 1965.

22. A. Ballerini, *Patologia di un eremitaggio. Uno studio sull'autismo schizofrenico*, op. cit.

23. Cf. G. Gaggero, "La musicoterapia nei processi clinici ed educativi", op. cit.

These ones are both the ‘experiential ground’ and the ‘seed’ in and from which those hermeneutic *paths* can ‘take root’ and develop, in the shape of concepts, in order to allow the investigation and the comprehension of the interlocutor’s personal *lived experiences* and of the categorial structures which, at a large extent, determine them.

Such comprehension necessarily *changes* the therapist’s level of consciousness; this change will conversely involve, in the clinical relationship, a change of the *quality of his presence*, affecting *eidetic aspects, style, listening* and testimony of *sense*.

Such *modulation*, rooted in the therapist’s capability of *listening* (to oneself and to the Other) and basically consisting in *musical dialogue*, is the very core of *care*.

In fact through it a patient can perceive that his communicating is something significant, the pursuit of which fully engages the therapist, who, in his turn, testifies (in this case *by music*) to the different evolutive phases of the *narration* they both give rise to by *searching together*.

Such perception can arouse in the patient a more or less profound consciousness of the *intentional* connections which his communicating is based on; from such consciousness a sense of *responsibility* for his communication choices arises, that in its turn generates an increase of his ability to self-determinate, and therefore, after all, of his personal *freedom*.

In this context the therapist’s *listening*, in the encounter with his patient, performs the following functions:

- it opens (and maintains open) the *dialogic* dimension;
- it clears the ‘relational and musical space’ that *belongs* to the Other;
- **it ‘calls’ Him to take up his own place in the relationship (as well as in the *musical dialogue* that develops within it) engendering an ever increasing consciousness and freedom²⁴.**

Just like the vital function of breathing consists of two movements - inspiration and expiration - and the former cannot exist without the latter, in the same way, in my opinion, *musical therapy* (and that ***music therapy hermeneutic circle*** which is its essential articulation) cannot find complete expression unless it includes two coessential moments: the intuition, empathic perception and testimony of *sense* in the stylistic and narrative dimension of *music* on the one side, and the discursive and

conceptual expression of its attempt at comprehension by *meanings* on the other side.

In this perspective, which can give rise to what I call ***phenomenological-existential music therapy***, the two mentioned dimensions (*music* and the *phenomenological-existential* philosophy) do not indicate a *how* and a *why* respectively. They are the two aspects of a sole movement, the ‘diastole’ and the ‘systole’ of a ‘listening’ and ‘understanding’ which continuously meet and passionately investigate their *why* – both by poetical and eidetic intuition and by conceptual articulation– and their *how* – from a ‘stylistic’ as well as ‘theoretical’ and ‘technical’ point of view..

Obviously all this must cannot be detached from an attitude of respect and listening of that endless *mystery* each man is, a mystery which everyone’s suffering directly or indirectly alludes to.

Such a method of work also requires that the therapist should be involved in (and prepared to) a ‘circular’ process in which the intuition and the interpretation of both his and his patient’s *lived experiences* and *categorial* structures of experience, supported by supervision of the same nature, concur together to outline an adequate pattern of guarantees for the care process.

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24. Sergio Erba pointed out that a therapeutic relationship can be both ‘asymmetrical’ (in relation to the different ‘roles’ played by the two partners of an analytical couple) and ‘equal’ (as to human dignity and assumption of responsibility). In this perspective he proposes the image of ‘fifty-fifty’, which underlines that a therapeutic relationship is based (for an essential ‘fifty per cent’) upon the patient’s willingness to meet the Other, and not only upon his needs or suffering. That is why the creation and preservation of such willingness are the primary aims of *care*; for the same reason, the therapist should avoid, even though he is motivated by the best of intentions, ‘invading’ the relational space that *belongs* to his patient, and whose ‘conquest’ by the very patient is actually a primary goal of care. (Cf. S. Erba, *Domanda e risposta. Per un’etica e una politica della psicoanalisi*, op. cit.).

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CHAPTER 23

*Music therapy in coma states and
post-coma*

**Transformational Humanistic Music
Therapy**

Ghiozzi, Roberto

Music has always been one of my great passions, and music therapy has been the other for the last fifteen years. They allow me to “be and go towards” what Gregory

Bateson defines as a “mission”. Once we identify our own personal mission, in the meaning that the humanistic sciences attribute to this term, we can have a possible answer to man’s eternal question “Who am I?” and another question which is just as important: “Have I got a mission to carry out here and now.” I have never been able to conceive of living without passion. By passion I mean being totally in the here and now, both in the pain necessary for growth and in the joy that is unleashed when coming into contact with the deep self resulting from an awareness of being a part of a greater system, connected to and interacting with all living things. This affirmation not only agrees with the intuitive wisdom of the mystics of all ages and religions, but is also supported scientifically by the discoveries of quantum physics that confirm the idea that living systems are intimately connected with each other even though each system is a totality in itself. My way of doing Music Therapy is carried out in light of this; in fact, the experimental model of Transformational Music Therapy, which is constantly evolving, wholly encompasses a systematic vision of life.

I began my activity as a music therapist with terminal AIDS patients at a hospital in Bolzano, where I continue to operate. The experience of working with people who are “on the edge” and observing the potential of sound and music, only continued to confirm the intuitive notions I had developed during my long musical experience in Italy and abroad as a soloist and as a member of musical groups and small orchestras. I extended my work as a music therapist to other areas: terminal patients; pregnant mothers; autistic and/or brain-damaged children; drug addicts; compulsive pathologies, such as pathological gambling; and patients affected with degenerative muscular atrophy, in a coma state, or in post coma. These activities are a part of a research project I am presently carrying out together with my Music-Therapy students, and in collaboration with Professor Franco Larocca’s group of study and research projects at the University of Verona (1),

Time does not allow us to illustrate fully this model today; however, I would like to give a few pieces of information that I hope will enable you to understand my way of approaching the patients.

The main principles of the humanistic sciences that I refer to are:

- 1.** An unconditional acceptance of the person and his/her present state.
- 2.** A profound empathetic listening of oneself and the other.
- 3.** Genuineness.
- 4.** Transparency.
- 5.** Congruency

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6. Use of a democratic style of thinking: pluralistic, non-dogmatic (the map is not the territory).
 7. Musical competence medium – high.
 8. Adherence to a systematic outlook on life.
 9. The individual perceived as a totality of the body-brain-spirit.

The number of cases of coma patients is constantly rising, and it appears that this tendency is presently irreversible. Up until not long ago these patients would have died. With its technical progress in reanimation, medicine today, in some way, has been able to avoid that death occurs and “hold on to” the lives of people who in previous years would have passed on to other realities. The coma is a prolonged loss of consciousness as a result of a numerous causes, which all have in common the fact that they affect the brain and threaten the patient’s life. However, the coma is in itself a pathological state; just as pain is distinct from the illness it reveals, so is the coma not be confused with the brain injuries of which it is a symptom. The coma has its own distinct morbid existence, its particular meanings, and its mystery. It reveals a specific kind of suffering and it requires a specific form of someone taking charge of a coma patient. After the coma comes the moment of “reawakening” of “coming back”, which is the opposite of the coma just as the coming to the surface is the opposite of a deep immersion. Some never come back again. They survive in a sort of limbo. You hear of a non-return, a vegetative state. For an indefinite length of time, they survive depending totally on medical treatment, suspended in the refusal, anguish, or acceptance of the family and the rest of us. Taking charge of a patient in a vegetative state exhausts one’s energies, it destroys the families, and, finally, it challenges our reasoning about ethics...¹ Conferences are often organised concerning the ethical issues related to this problem. The questions are: Is there consciousness? Is there mental life? Are they dead? Are they alive? Are they still people? What is the quality of their life?

The answer is simple for us: every question is legitimate; however, the person remains a person with all his/her inalienable rights! Science with its sophisticated techniques has been able to “hold on to” these patients; it is now necessary and our duty to do as much as possible to improve their quality of life in some way using our hearts and all the means we have at our disposal. There is the risk that we label them as “vegetative” and “park” them in some clinic. In this case, which implies our giving up, these people remain isolated. In physical and psychological isolation, there remains only the survival of the organism; but only the survival of the organism means simply vegetating. In isolation, there is no life; there is existence but not the vibrating of essence. Our research shows that, in many cases, it is possi-

ble to arrive at communicating, at bridging a gap with something that seems inaccessible.

We have known for many years now that perceptive and emotional musical experiences cause variations in blood pressure, in the cardiac frequencies, in breathing patterns, in the psycho-galvanic response and other vegetative responses. These variations represent the reflection of the psychological processes on the vegetative system activated by music. 2 Music can prompt a vegetative response even when the sounds are not perceived consciously, as for example during sleep. I could say, with a great deal of caution, that a number of people in a vegetative state seem to have had, within the therapeutic rapport, emotional responses during the listening of both recorded music and that improvised by the therapist. We know that in a healthy person the sound-music stimulus acts on a physical and psychological level and activates a continuous interaction between these two levels. A healthy brain reacts to any listening of music. Music and sound solicit emotions. If the damaged area does not include the emotional part of the brain, specifically the amygdale, can the person in a vegetative state in some way experience emotions? This would enable the person's internal environment to be in contact with his/her external environment. The neuro-scientist, LeDoux discovered that, besides the path that goes from the thalamus to the cortex, there also exists a bundle of thin nerve fibers that go directly to the amygdale. This path, which is finer and shorter, may allow the amygdale to receive certain input from the sense organs directly; thus, it could start responding before the same input has been completely recorded by the cortex. The results of our study indicate that amygdale allows us to have emotional reactions without involving the superior cortical centers. "From an anatomical point of view, the nervous system can act independently from the neocortex". 3 If an undamaged amygdale allows a person in a vegetative state to experience emotions, and from LeDoux's research it appears to do so, what meaning can all of this have? Naturally, this is only a reflection I wish to share with you and one that leads to many questions, keeping in mind that we are operating in a context that requires caution, respect and scientific verification.

Two years ago, I began a research project with patients in a coma and post-coma state at the hospital "S. Cuore di Negrar" in Verona. (1) What I will be talking to you about is the research we are carrying out and will continue for at least the next two years. The study is being carried out together with the important help of three of my students and music-therapy colleagues: Professors Giulia Stola, Francesca Bresola, and Elisabetta Verdolini. The cooperation of the psychologists and rehabilitation therapists in the hospital centre for patients in a vegetative state has been invaluable and irreplaceable.

In these first two years we have worked with twenty people, some of whom have been in a coma state and others in a post-coma state. Having decided from the outset, together with the head of the department, I began this experience without making any use of the electroencephalogram in a music-therapy setting; however, I was constantly informed of the results of these tests and, especially, of any recorded data of potential importance. I listen to the changes in the heartbeat. I do not make any use of sound filters. We rarely administer recorded music, as improvisation is our main modality. Music therapy, I believe, can and must give its own original and specific contribution within the framework of a team approach. The results we have been getting have been excellent and are considered as such by the doctors themselves in the centre. It appears that even in the case of patients in a coma state, the significant relationship is the basis for establishing a process. Relationships as closeness, profound listening, trust, and empathy. All of this generates a positive energetic quality that seems to offer the possibility of communicating on a profound level. This is one of the experiences I have had and I am having now with terminal patients, and it seems that this is also possible with people in a post-coma state.

The study is carried out in the following way:

The doctors indicate the patients, and as a result, I sit in during the doctors' daily routine visits with the patients in the ward. After consulting with all the staff responsible for the patient, a decision is made of my taking on the patient. At this point, the first phase involves interviewing the relatives of the patient in a flexible manner.

This consists of:

1. General information about the patients different phases in life from infancy to the present.
2. Information about the character.
3. Studies completed.
4. Musical background.
5. Interests: Literature
Sports
Hobbies, etc.
6. Favorite flavours-scents, flavours-scents of the family environment and those from work.
7. Information about the patient's spiritual sphere.

8. Relationships in the family and with friends. This includes both the positive and negative ones.
9. Any physical reactions observed by the relatives during their visits to the hospital.

Subsequently, the observation sessions with the patient begin with the following parameters:

1. Calibration – Modelling - Mirroring
2. Rotation of the three perception positions.
3. Observation of the micro-movements, the breathing rhythm and the physiology in general.
4. Any reactions to any environmental stimuli.
5. Prompt-test of recorded songs.
6. A constant contact with the patient's deep self by the music therapists.

Every session is recorded on video, examined frame by frame and then taken to the supervisor.

Neurophysiologic and neuropsychological studies concerning the relationship brain-music are interesting but still limited in number, even if there is a great deal of interest in this area and research is in constant growth. As music therapists, it is important in our work to assess any brain damage in each patient and understand as much as possible about how a brain which is undamaged functions. An important part of our work consists of observing the different sessions of physiotherapy, speech therapy and other treatments from which we obtain vital information. Lastly, the cooperation from family members can also lead to an important contribution.

The patients we are involved with are in the following states:

1. Coma state.
2. Vegetative state.
3. Minimum-response state.

The cuts taken from a few video recordings will present three people who at the time of our first contact were in a vegetative state (V.S.) but are now in a minimum-response state (M.R.S.). The condition of these three patients is in slow positive evolution.

It is important to maintain the same days and the same hours for the sessions to produce in some way the coordinates of time and space. An objective we can set is that of helping the patient to reacquire a sense of rhythm: sleep-wakefulness, time-rhythm of life. Rhythm is the basis of every vital manifestation of life from the amoeba onwards, and it is the essential characteristic of music.

Starting immediately from the first session, we use a calibrated voice on the breathing pattern. The modelling of the breathing pattern plays an important role with patients who are still in a coma state, patients in a vegetative state and patients in a minimum-response state. Personally, I feel that the voice calibration on the breathing pattern represents one of the basic rules of music therapy. We carefully experiment various sound parameters: pitches, tones, frequencies, energy-intensity and dynamics. We try to stimulate the senses through several receptive channels by exposing the patient to the vibrations and the resonance of musical instruments, and to the different voices of the therapists. Thus, sound and music contain a potential for eliciting emotions, and sound vibrations penetrate through every internal organ. Other stimuli are produced by means of physical contact: the psycho-tactile approach and the sound massage, which is a technique that has been experimented with and included in transformational music therapy. In addition, we use stimuli on an olfactory level: essences, scents of any kind that the patient likes or are simply familiar to him/her. We often use the piano to do clinical improvisations. During the improvisation, one of my assistants uses her voice and massages the patient by pacing her voice to the music that is generated. The improvisation is unpredictable. It is a process that comes to life starting from observing the physiology of the patient, from his/her breathing pattern, and from the energetic quality of the people interacting. The modalities described here, together with several others, are not carried out in a fixed sequence but are chosen on each occasion depending on the situation we are presented with. Not all days are the same, and often the patients come to us after having undergone difficult tests; consequently, we regulate our actions and operate according to the moment.

The cases presented at this conference are about M. F. and I. They are three people, whom we are still following, hospitalised in a vegetative-state ward,

M. is a young person in a vegetative state for over seventeen years. Before the music therapy sessions, she had only undergone medical treatments and physiotherapy primarily to avoid any complications. At the time of our first encounter, M. did not emit any sounds; the look in her eyes was defined as 'worrisome' by the medical staff; she would stare into space; there was no expression on her face; and she rarely made any eye movements. Until the fifth session there had been no variations in M.'s breathing pattern with all the initiatives we undertook. We used sound stim-

uli with different intensities, pitches, tones, dynamics, and both recorded music and improvisations. These stimuli were re-enforced with psycho-tactile contact and sound massage. In the sixth session M.'s facial expression and the look in her eyes begin to change: her face seems brighter and to have acquired more colour. We can observe variations in her breathing pattern; M. is now producing longer and longer sighs and moves her eyes as if she were searching in the direction the voice or the sounds are coming from. In the following session, something new happens: M. appears to be filling her mouth with air as if she were preparing to emit a sound. In the session after that, at our request she turns her head towards us; and during the same session, she is vocalizing for the first time and interacting with us. The doctors, the nurses and the relatives confirm a greater "presence" in the patient, which is activated every time the patient has a session of music therapy. The staff members who have been taking care of her for over seventeen years are quite surprised when they watch the video recordings.

The second person is F., a young man slightly over thirty years of age and hospitalised for about two years.

It was an interesting session when I proposed that F. listen to the piano, note-by-note, starting from the highest note. During the listening F. moves his left hand and brings it towards his right which is usually immobile. For the first time we can see the right hand making micro-movements, which are now repeated regularly.

Another significant episode: F. begins to move his left index finger intentionally to make a sound on the cetra. We believe that this sound feedback is very important for him. In the following sessions, he interacts with the sounds he produces as he is breathing in following the stimuli suggested by the therapist on the piano. We can see a change in F.'s physiology and his breathing rhythm. Every time he is taken to the music therapy room, he seems to be aware of the environment and he seems to activate himself as if he were getting ready to cooperate.

The third person is I., a young woman hospitalised for over two years. She is presently the least responsive with respect to the two people described previously. She has had reactions that we could define with a certain caution as emotional. She can only open one eye which she usually keeps closed. In some sessions, she seems sensitive to physical contact. During the improvisations on the piano, certain events or micro-events take place that could be considered of great importance: she opens her left eye, the look in her eyes seems strangely present, and she seems to look around for a few short moments as if she were suddenly present.

Conclusions:

In these cases, every perceivable variation can represent a small-great victory or, in any case, a precious piece of information in establishing a channel of communication. When we hit the rock bottom of our sense of uselessness and accept the ensuing sense of frustration, without “turning our backs” on the other; when we remain at our place and put our hearts and minds at the service of the other person, this will permit us to reach unexpected resources in ourselves and the other person. The point of departure in this study is the existence of human reciprocity. 4

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CHAPTER 24

Evidence of no effect, no evidence of effect, or a question of review methodology? A structured literature review of the treatment of people who

have experienced traumatic brain injury in music therapy.

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Abstract

Music therapy literature is varied, ranging from anecdotal reports to academic articles and reports of formal studies. References to this material have not existed in one place and identification has been difficult. Once identified, we will need to assess and review the articles to objectively assimilate the findings.

We began a Structured Review Project in April 2002 at the University Witten Herdecke that reviews music therapy literature. For this project, a new electronic database has been created, the Music Therapy World Journal Index (MTWJI), which contains references to all articles in selected music therapy journals. Both the Structured Review Project and the MTWJI contribute to a central database of references and reviews of music therapy literature.

The presentation will focus on the results of a structured literature review into music therapy with people who have experienced traumatic brain injury. Following an overview of the literature, I will discuss selected clinical reports and formal studies in detail. The identified material provides an excellent example of the large variety of types of literature. Contemporary evidence research and systematic

review methods are challenged by this variety. Suggestions of solutions and issues related to structured literature review methods will be discussed.

Powerpoint slides of the oral presentation

FIGURE 1.

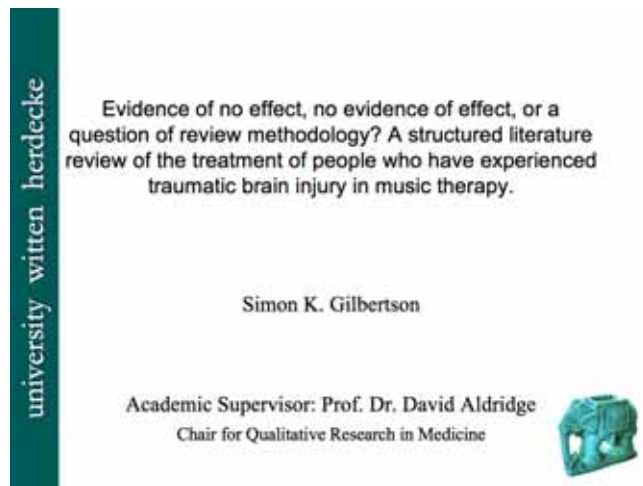


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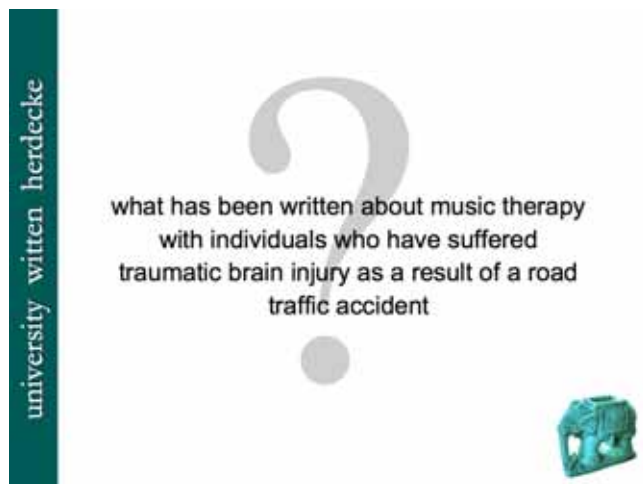


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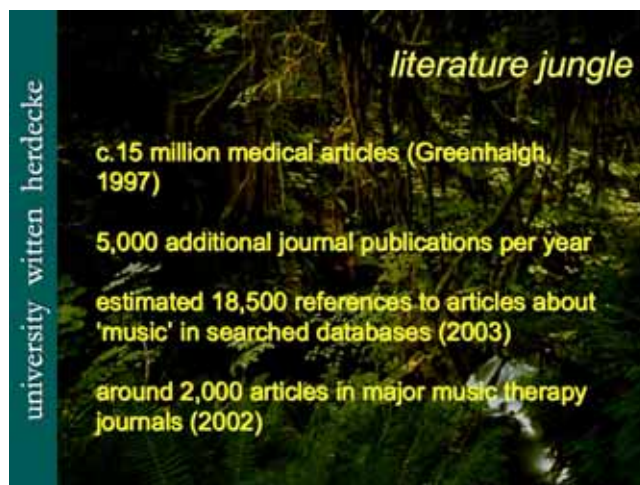


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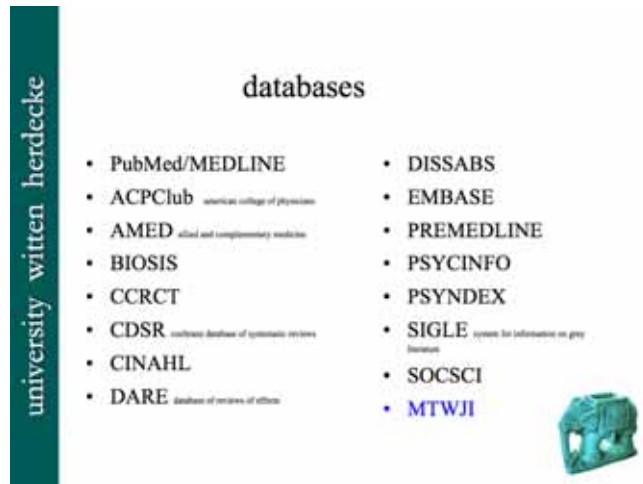


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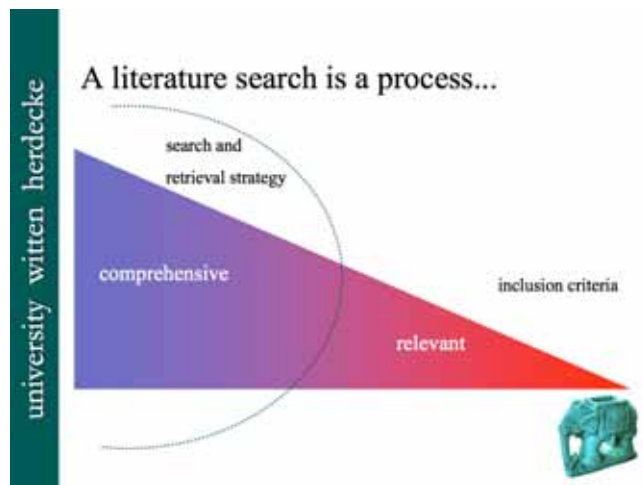


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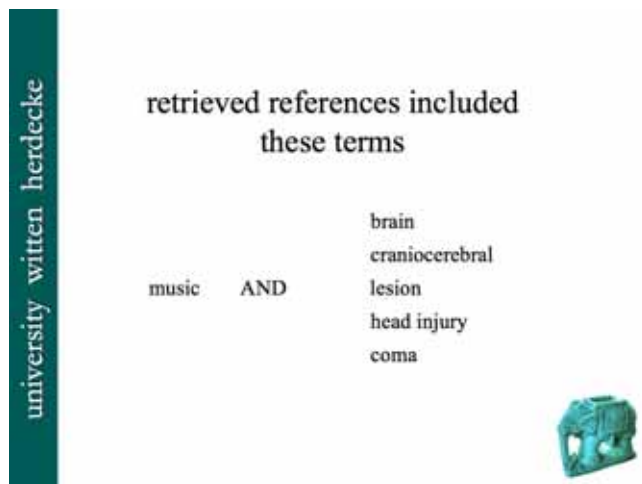


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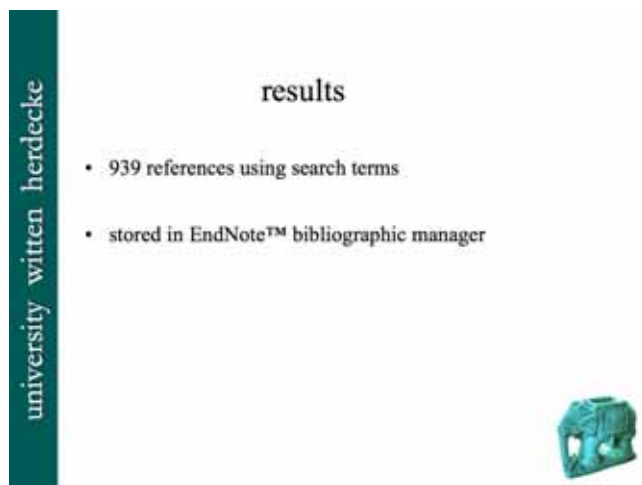


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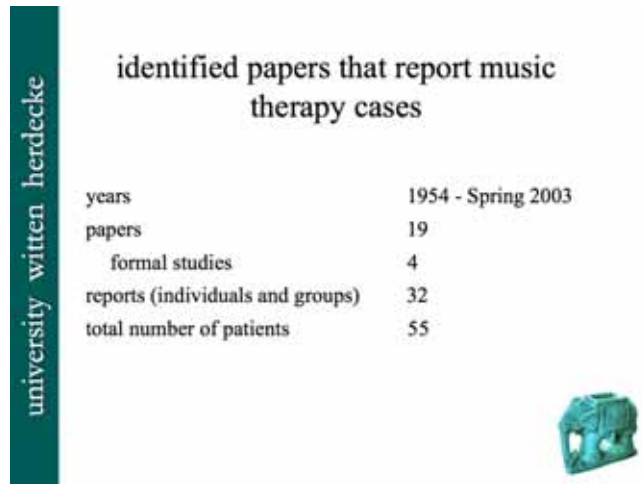


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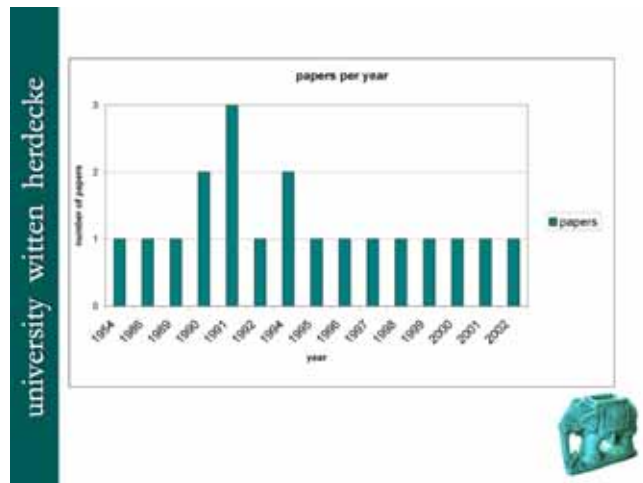


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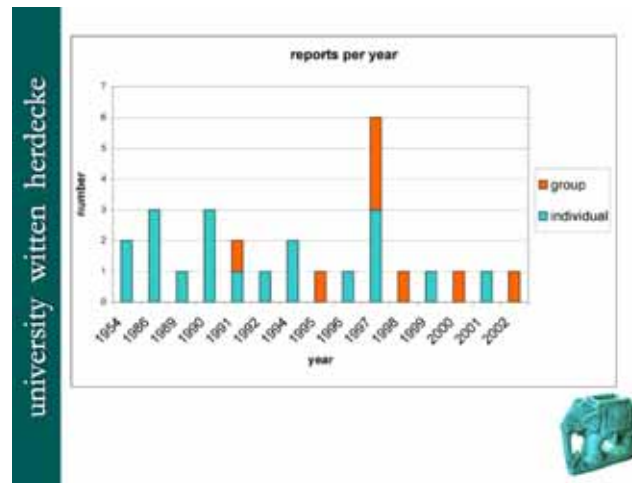


FIGURE 11.



FIGURE 12.



FIGURE 13.

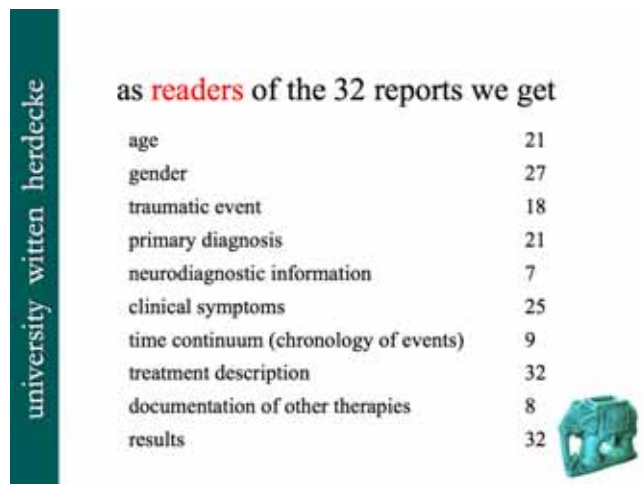


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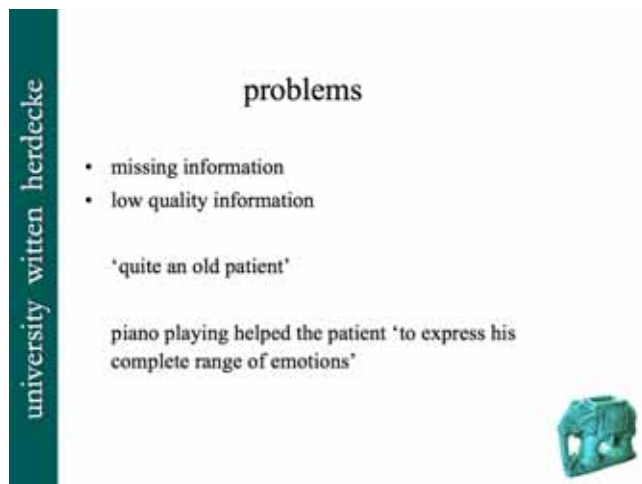


FIGURE 15.



FIGURE 16.



FIGURE 17.



FIGURE 18.



FIGURE 19.



FIGURE 20.

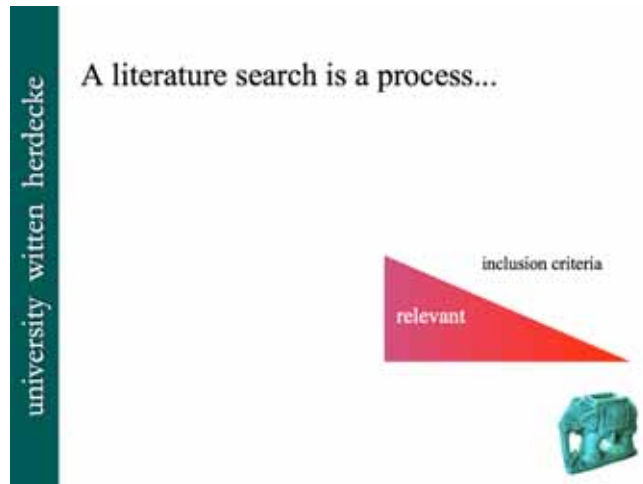


FIGURE 21.



FIGURE 22.

| | Age | Gender | Trauma | Diagnosis | Neuro-diagnosis | Symptoms | Time | Treatment | Other therapy | Results |
|------------------------------|-----|--------|--------|-----------|-----------------|----------|------|-----------|---------------|---------|
| Gadomski and Jochims (1986) | 40 | Y | Y | Ataxia | Ataxia | Y | Y | Y | Y | Y |
| Jochims (1990) | 40 | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Jochims (1992) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Jochims (1994) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Nayak and Agnew-Brown (2000) | Y | Y | Y | Y | Y | Y | Y | Y | Y | Y |
| Magre and Davidson (2002) | 40 | Y | Y | Y | Y | Y | Y | Y | Y | Y |

FIGURE 23.

| | | |
|--------------------------|---|---|
| Gadomski, Jochims (1986) | Male, Ataxia | Increased expressive ability: piano playing helped pat. to "express his complete range of emotions" (p.109) |
| Jochims (1990) | Male, Transitional psychosis | Isolated speech event related to comments of pat. severe skin scratching sung by therapist. Event reported to be unique |
| Jochims (1992) | Male, 47 yrs "post-coma" | After 6 sessions where pat. deeply sighed 2-3 times, pat. played percussion instrument in music structure of greeting song. Involvement repeated twice then no longer |
| Jochims (1994) | Male, 40 yrs, hobby musician: buccofacial apraxia, left paresis, neglect, mutism, ideomotor apraxia | Developed structured music playing, through activity in music therapy showed contrasting behaviour to apathy in all other situations |

FIGURE 24.

university witten herdecke

Nayak and Agostinelli (2000) 6 Female, 4 Male (Control 6 Female, 2 Male)
mean age 59.89 (31-84) Stroke or TBI, FIM score 4.5 or lower, Faces depression score 4 or more.

Exclusion: 'nasogastric tubes, interavenous lines, uncontrolled agitated behaviour, or any serious behaviour or any serious medical conditions were not included. Also those with sensory, perceptual or marked cognitive impairments (e.g. hearing impairments or aphasia) that might have intervened with their ability to participate in the study were not included (p.276)

instrumental improvisation was included alongside welcome song, singing, composition, playing instruments, performing or listening to music

positive trends in involvement and motivation, mood and social interaction



FIGURE 25.

university witten herdecke

Magee and Davidson (2002) MS (5 Ss), TBI (5 Ss), stroke or anoxia (4 Ss)

2 music therapy sessions (one precomposed songs, one improvisation)

Significant positive changes on continuum of composed-anxious, agreeable-hostile, and energetic-tired mood states.

No correlation was observed between patient groups or treatment modalities

Additional inclusion criteria: the subjects should show 'evidence of music having a significant meaning in their lives (e.g. background in music associated activities; being an avid listener of music' (p.29, Appendix)




FIGURE 26.

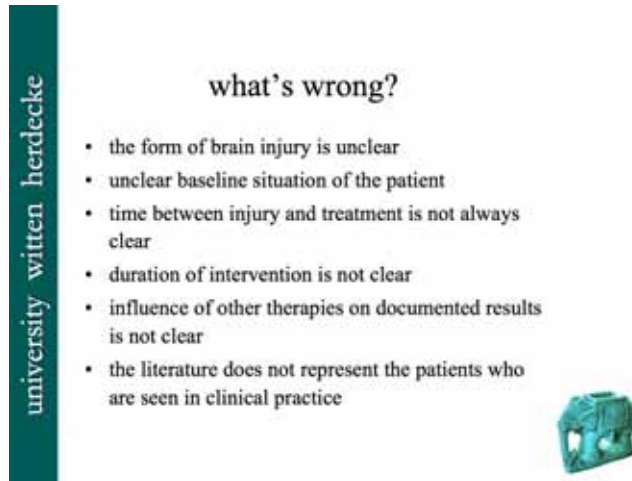


FIGURE 27.

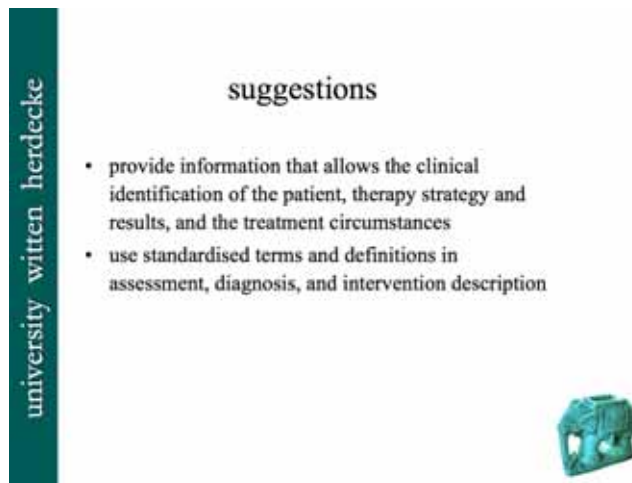
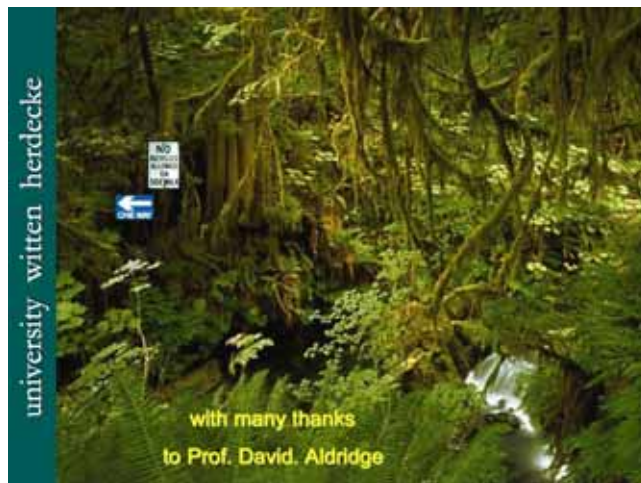


FIGURE 28.



*Tools of the trade: Improvisation,
expression and music technology in
music therapy*

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Abstract

We may learn about improvisation and talk of the importance of expression in music therapy, but how much time do we actually invest in learning about the phys-

iological and pathological demands human variation makes upon making an adequate selection of music instruments with our clients?

Electronic instruments provide unique possibilities of musical creation for people living with severe motor restrictions. Though vocal improvisation has commonly been suggested for these people, this may be related to an absence of adequate alternatives and may also be inaccessible for clients with voice disorders.

This presentation will focus on a case report of a young man who experienced traumatic brain injury related a motorcycle accident, experienced severe loss of movement in all extremities. It will describe the processes involved in designing and adapting electronic instruments for the individual needs of the client, and provide commented examples of music improvisations of significance in the therapy process.

CHAPTER 26

Storycomposing

Hakomäki, Hanna

**This presentation has been send as a
Powerpoint file**

Introduction

Storycomposing was born in a nursery in Espoo, Finland with children under school age in their creative music lessons on the 17 th of April 2000. The 3-year project was run by the Resonaari Special Music Center. The developer of Storycomposing is Hanna Hakomäki, a piano teacher and a music therapist. Storycomposing can be done with your own children, in a day nursery or together with friends. Storycomposing can be a way to teach music or to play some instrument. In Storycomposing children and adults with special needs can participate equally. Also mentally challenged people can storycompose. Storycomposing can be a way of rehabilitation or music therapy. It can also be applied in many other ways to produce creative methods and it can be combined with other therapies for example with family therapy. See the pictures 1-21.

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www.mll.fi



"I'm thinking, I'm wondering,
I do know and I have feelings.
And someone is listening me."



"I can play, I can sing,
I can tell stories.
I can storycompose!"





"My songs and stories
tell about happy, sad,
nice and even scary matters.
It feels good to play them especially
with adults or friends."



"When my storycomposition is written down
I can play it again and again.
It's fun!"





Hanna Hakomäki

- A Music Therapist and a Piano Teacher
- Master studies in music therapy, Jyväskylä University
- Music therapist in the foundation for the rehabilitation of children and young people (MLL)
- Piano teacher
 - students of all ages
 - mentally challenged people
 - people with learning disabilities
- 20 years experience with mentally disabled people



A three-year project in a nursery

- 1999-2002
 - to test and develop the possibilities of the Figurenotes with small children
 - also a therapeutic aspect
 - run by the Resonaari Special Music Center
- Children were in the age of 3-7
 - in groups of three once a week
 - also children with special needs
- Piano was the main instrument



Storycomposing was born on the 17th of April in 2000

- That day
 - I found out that the children can and will create their own music and stories
- After that
 - all the music was made by the children
- Children were
 - happy, interested, motivated, good at co-operation and proud of their storycompositions
- All children
 - could participate equally in Storycomposing in spite of their special needs



Susi – The Wolf

Susi The Wolf

Tessa Eronen 3 years
17.4.2000

| | | | | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Su - si | si - voi | näin | AUUU | | |

The Wolf was howling so AUUU.

| | | | | | |
|---|---|---|---|---|---|
|  |  |  |  |  |  |
| Kat - soi | kuz - ta | päin | AUUU | | |

Watching the moon that glows AUUU.

Original written by Hanna Hakomäki



The four principles that Storycomposing always includes

1. An opportunity to musical expression



2. Interaction



3. The composition is written down



4. The concert



Drawings by Jussi Viikari



An opportunity to musical expression

Storycomposing allows an opportunity to express one's ideas, thoughts, matters and experiences in a musical way.





An opportunity to musical expression

When you are Storycomposing you don't need any musical talents or prior studies in music and a piece may appear without supervising or teaching.



Interaction

There is always interaction in Storycomposing. There is a storycomposer and a co-storycomposer who listens and writes the piece down.





Interaction

A storycomposition can be for example a song, a composition, a play or a musical story.



The composition is written down

The storycomposition is always written down. Use a notation with which the storycomposer can play the piece again.





The composition is written down

A storycomposition is important in a cultural way, as educational material and as material for a music therapy process.



The concert

Storycomposing includes a concert. It is an event where a storycomposition is played to someone who is important to the storycomposer.





The concert

The concert can take place for instance in a nursery, in a music school or in the hospital. The audience can be family members, friends, a peer group, a teacher or a therapist.



The four principles that Storycomposing always includes



1. An opportunity to musical expression



2. Interaction



3. The composition is written down



4. The concert



Storycomposing is a suitable way of working...

- in creative music activities
- in music lessons
- in music therapy

Storycomposing can be applied...

- to other creative working methods, for example
- to dancing, acting, storycrafting,...

Storycomposing can be combined...

- with other therapies, for example
- with family therapy, art therapy, occupation therapy,...

Storycomposing can be used...

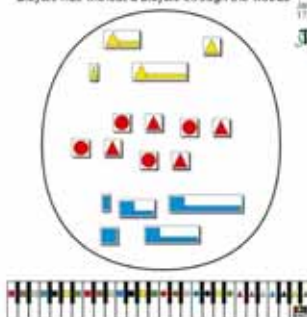
- in groups and individually
- with children and adults

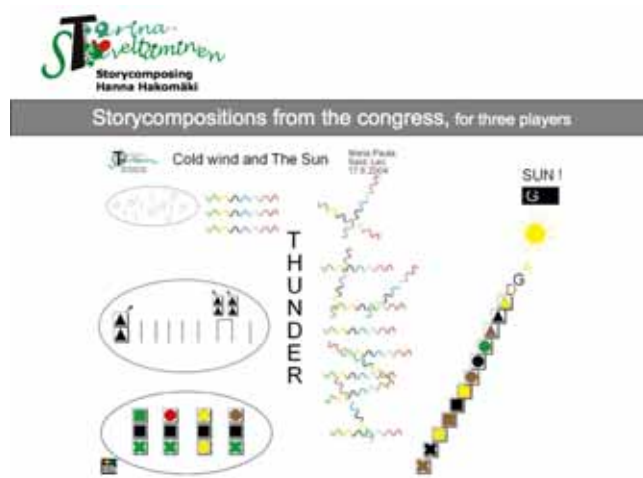


Storycompositions from the congress, for three players

Bicycle ride without a bicycle through the woods

Riikka-Eva
Järvelinen
17.5.2004





CHAPTER 27

*Music therapy for women
with advanced breast
cancer*

Hanser, Suzanne B.

I am a music therapist. I work with people who have cancer – people like Geraldine, people who are scared and courageous, weak and strong, pessimistic and optimistic.

For Geraldine, cancer infiltrated the healthy cells of her body, slowly devouring them in the breast and surrounding lymph nodes, causing them to divide insidiously. As she waited for biopsy results, the cells continued to multiply. A mastectomy scooped out the tumor and positive nodes. Chemotherapy fought more than cancerous cells, depleting the robust ones of their nutrients while causing lethargy, nausea, headaches, and perhaps the most obvious side effect, hair loss all over her body. Radiation scorched her skin, making it necessary to apply cornstarch to her chest daily. Still the cancer grew. Geraldine's cancer cells entered the lymphatic system, and spread further. Her cancer had metastasized to the bones and brain.

We made an appointment to meet during one of her chemotherapy infusions, during which time she would receive more toxic chemicals through her veins. I arrived for our first session just after the nurse had attempted and failed three times to find a blood-letting vein.

I told her I was there to fill her with music.

She settled back in relief, her frame so slight, the indentation in the bed seemed only a shadow.

I unrolled my alto recorder from its felt wrapping. Geraldine looked over with interest. This instrument, one of my favorites, is handmade out of dark, grained walnut, and its wood is naturally shiny. I handed it to Geraldine, suggesting she feel the smooth exterior. I asked her to imagine how the circulating air of my breath would sound. She closed her eyes.

Gently guiding the recorder to my lips, I began a restrained improvisation of long, low sounds. Then abruptly, I tweeted some bird-like tones in its upper register. Geraldine smiled. I tooted a little game, moving back and forth between the contrasting styles. Then, I played a lengthy phrase in the Dorian mode. I have found that my patients are not accustomed to hearing a melody centered on the second tone of the scale, and they often describe its effect as sad, contemplative, or melancholy.

My intention was to interpret Geraldine's mood and to influence it, by making gradual changes in tempo and melody. Geraldine's expression coaxed me to continue, but I was curious to hear her interpretation of the music, to see if what I thought was going on inside her was correct.

She said she didn't want it to end. She said she saw the woods where it was made. It created a dense forest, lush green, ferns, shade, leaves in the breeze. She was there, and far, far away from the hospital.

I unclipped the rectangular case that housed my twelve-string lyre. I asked her to close her eyes once again, to breathe in the music, and to let it fill her body. I fingered some familiar folk songs from different periods of music: *'Tis a Gift to be Simple*, *Scarborough Fair*, *Theme from the New World Symphony*, and *My Bonny Lies Over the Ocean*. I played a glissando, the running scale from one end of the instrument to the other. I mimicked the sounds of the wind blowing across the strings with short flicks of my wrist.

his time, she said she was at the ocean. There was a cool breeze and warm sand at her feet. She felt unbelievably close to it all, accompanied by a heavenly sound. She asked me if people ever listen and think they died and went to heaven.

So we talked about heaven, and she told me that she followed that breeze up into the clouds. It was white and blue, just white and blue, baby blue. It was cool, but not too cool. It felt great.

When I talk with a patient about dying, we are on intimate terms. I was grateful that the images inspired by the lyre's music offered her a hopeful glance at life after death, and I was honored she shared those visions with me.

I brought out my guitar and hummed a few songs without words. Geraldine fell asleep, breathing along in contented accompaniment.

At our second session four weeks later, Geraldine greeted me with a grand smile. No longer did I sense the stately distance that struck me at our first meeting.

She told me that when the nurse got out that big syringe earlier, Geraldine automatically closed her eyes, and started singing *'Tis a Gift to be Simple*. She didn't feel the prick.

"She got me on the first try!" she said. "Do you believe it?"

I said I believed it.

Other patients had found that music was a great distraction from pain when they focused on its sound. I was thrilled it worked for Geraldine even before I had the opportunity to suggest it. My research with women in labor and delivery, based upon my own personal experience when I had a stillborn baby, confirmed that the sounds of music could focus one's attention like an auditory focal point. Other research studies support the use of music therapy in pain management. At that moment, I was simply thrilled that Geraldine had found a new way to cope with the bothersome, painful and anxiety-ridden experience of needle sticks.

Later in the session, I used the hand chimes and temple bells to create an exotic mood. Because it requires nothing more than a snap of the wrist to produce a lush, lasting tone, Geraldine was able to improvise with me while being hooked up to the IV. I gave her two of the ten chimes I have which cover two octaves of the pentatonic scale. She had instant success mastering the strong and long tones of the chimes. Once activated, the bars sustained their ring while setting other metal objects in the room into resonance. The result was a pulsing aura encircling our bodies.

When I rang the temple bell again for Geraldine, she sang the deep pitch on "mmm." I played a bass note and perfect fifth above, then a fourth and third beyond, to create one harmonious chord.

Her hum jumped an octave higher as she rolled over to let the sounds enter her right ear unobstructed. I selected random bars, but the effect always buzzed the body, messaging the skin as gently as a feather. I let the collective notes vibrate until the sonorities drifted off. At the end of the 15-minute opus, I let the temple bell ring until I was sure Geraldine could hear only silence. Her eyes opened easily and reflected a sparkle I had not noticed before.

She said she was in an ancient monastery on a mountain top. It was engulfed in misty clouds. It seemed like a magical home for her spirit.

I smiled and handed her the two chimes that most closely matched her initial hum. Her face shone in the metal of the bars. We moved together in a musical conversation, creating a new song with each pattern. Sometimes, I led the discussion. Sometimes, Geraldine introduced a rhythmic theme. I responded to her, then, she to me. We chased each other in the music, gave each other space, listened, frolicked and harmonized without speaking a word. Our composition pleased her. It confirmed in me the idea that these beautiful instruments could express something of Geraldine's essence, something unnamable, something indescribable. And then, she put words to what I thought was without language.

She asked, "Do you know what that was, in that music we made?"

"No," I said. "Tell me."

"That was my soul."

In our third and final session one month later, I strummed a few guitar chords and asked her if she would like to write a song.

"I'm not that talented," she said.

So, I placed the guitar across my lap and found two minor chords in Geraldine's vocal range. I played an Alberti bass to stretch out the harmony. After a few measures, Geraldine began to sing a primitive, modal melody. It seemed to spill, then build, then moan, then subside. Her tone was guttural, a low, melting wail that told a story of long-lost love, exotic places, children's cries and distant voices. I thought it was a sad song, but Geraldine described it as the song of her life - a full and meaningful life.

I worried after that session with Geraldine. She was so frail. The white that should have surrounded her pupils was red. The rose tone that should have covered her

body was as white as a tissue. I felt that if I did not watch her closely, she might slip away or turn into a ghostly image.

Three months passed and I wondered about Geraldine. Then I ran into her in the hospital lobby. She called out to me.

"Something incredible has happened and I have you to thank. I'm cancer-free! My markers don't show any cancer, and they can't explain it. I thought about what has been different in my life over the last six months. And I have to say, it's the music.

I stammered a "but," then thought about what she was saying. And while I know the evidence that immune function is affected by the suppression of the stress response, I did not believe music therapy had this kind of power.

"You know that music doesn't cure cancer," I told her.

"Of course. And I know that the cancer can return at any moment," she said. "But, right now," she said, pointing her index finger at me, "I feel great and I know that your music helped me."

"No, no," I insisted.

Yes, yes," she said.

Geraldine was one of seventy women with metastatic breast cancer to enroll in my research project, a randomized, controlled trial to investigate the effects of music therapy on quality of life, distress, and spirituality. Geraldine is one of 668,470 women in the U.S. who have cancer in the U.S. There are also 699,560 men in the U.S. who have this diagnosis. These statistics indicate the depth of the need for techniques that help patients take control of their lives and live more fully and more fulfilled. Music therapy is a strategy that has a growing body of clinical research to support its efficacy and a growing body of patients who have benefited from its application.

Thanks to greater acceptance of music therapy as a form of complementary or integrative medicine, more patients have access to these services. Thanks to people like Geraldine, music therapists are learning about the immense potential of their treatment modality for helping patients cope with cancer and live better lives.

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CHAPTER 28

*Video micro analysis in
music therapy research, a
research workshop*

**Holck, Ulla; Oldfield, Amelia & Plahl,
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Introduction, shared

This presentation is based on three Ph.D. dissertations about music therapy interplay with children with severe functional limitations, including children with

severe autism (Plahl 1999/2000; Holck 2002; Oldfield 2004). These children are typically socially withdrawn and also have considerable difficulties in the area of communication, verbal as well as nonverbal.

Because it can be very difficult to register communicative behaviour of these children in normal real-time observation, video can be an extremely useful tool for recording music therapy interplay, thus making it an object for analysis and reflection. Often it is necessary to analyse on the micro level, in order to register who is doing what, and when.

On the other hand, in practice only segments of a series of music therapy sessions can be micro-analysed. This means that an extensive selection process is required, whether by criteria of time or specific qualities. All research requires focus, and thus selection, but this process has great weight in video microanalysis.

By choosing video microanalysis, one chooses a method that will provide certain types of knowledge and not others. But with music therapy's many facets, such as client variation, approach and relationships to medical, social and psychological fields, different research approaches are needed to cover the whole area (Aldridge 1996).

The delineation between quantitative and qualitative research refers to quantitative and qualitative data and methods, respectively. However, in practice many studies contain both data types. Therefore it is more meaningful to distinguish between types of knowledge that are accessible within a given subject or method (epistemology).

In quantitative video research, the effect of music therapy is typically shown, through analysis using a series of predetermined and operationalised items. Here the aim is generalisations that are (relatively) above time and context. For example, in medical research, people are classified and analysed in relation to numerical representations of norms (Aldridge 1996). A test that shows a child's normal development can therefore reveal deviations from the norm in the individual child.

In qualitative video analysis, which is highly influenced by ethnographic research, the aim is to reveal connections, patterns or phenomena not previously described, and often implicit for the people being observed. As the patterns found are always related to the specific historical and cultural frame in which they take place, here the interpretation is dependent on the context (Lincoln & Guba 1985).

In the following we will each present our own approach to Micro Video Analysis, and involve the workshop participants as well, in exploring different examples of how these analysis can be done.

Video Micro Analysis – from a qualitative approach

Holck, Ulla

INTRODUCTION; THE POPULATION AND THE AIM OF MY RESEARCH

In music therapy interventions for children with severe functional limitations, including children with severe autism, one of the primary goals is to develop the children's ability to participate in social interaction and communication. Quantitative research has proven music therapy to have a positive effect in helping children with severe communication difficulties to improve their capacity for social and pre-verbal skills such as response, initiative, turn taking, imitation and vocalisation (Müller & Warwick 1993; Bunt 1994; Edgerton 1994; Aldridge et al. 1995; Plahl 2000; Elephant 2002; Oldfield 2004).

While often the relative quantity of communicative behaviours increases, it can still be hard for the therapist to interpret and respond to them as such in an ongoing interaction. Analysis of interactions between adults and young disabled children (among others those with autism and Down's Syndrome) show that even the child's own parents can have problems in understanding responses because of their frequently weak, random, or ambivalent character (see Rogers 1988 for a review). At worst the problem is twofold; the child shows no sign of understanding the adult's initiative, and the adult cannot read the child's reactions as meaningful because they seem to occur without context.

Developing an isolated child's desire and ability to engage in communication requires creating an interaction form that both partners find meaningful and enjoyable (Klinger & Dawson 1992; Schuler et al. 1997). At moments when this succeeds, both partners seem to perceive and follow each other's actions, and a mutual and playful interaction can be created (Rogers 1988). In this way, meaningfulness refers to interactions where *both partners contribute to the continuation of the interaction* because it seems to be meaningful to do just that – even when we can-

not know what precise meaning the interaction has for the child (see Holck 2002, 2004).

From this perspective, *one* reason for music therapy's capacity to engage these children could be the way it can facilitate the creation of *frameworks for meaningful interaction*. In a qualitative doctoral study involving video analyses of music therapy interventions with this population (Holck 2002), I explore some of the conditions through which this happens, combined with extended micro analyses of patterns of interactions, showing mutuality, expectations, and other signs of meaningful interactions.

It is important to be aware that if the aim of the research is to prove music therapy's effect on the child, only clearly communicative expressions should be measured. However, if the aim is to analyse the interactive process *between* child and music therapist, one must consider whatever the participants themselves react to as communicative in the situation.

QUALITATIVE OBSERVATION RESEARCH

Following this pragmatic approach to communication it makes sense to use Qualitative Observation Research, with reference to the ethnographic research tradition and Naturalistic Inquiry (Lincoln and Guba 1985). Generally, the main question in Qualitative Observation Research can be formulated as "What do people in this setting have to know (individually and collectively) in order to do what they are doing?" (H. Wolcott in Silverman 1993, p. 37). 'Knowledge' does here include implicit knowledge as well as purely procedural experience.

In answering this question, the aim of Qualitative Observation Research is to investigate the 'practices' of the persons being observed (Silverman 1993). 'Practices' are the (often implicit) ways in which persons do things together, habits, etc., that are built up gradually through many meetings over time. Therefore the object of Qualitative Observation Research is typically the repeated actions, themes or interaction patterns of every day situations. Pattern-generalisation is one of several qualitative ways of addressing the question of validity (Lincoln & Guba 1985; Silverman 1993), as repeated interactions between child and music therapist, for example, show that these actually are interactions and not arbitrary parallel incidents.

Let me give an example from music therapy: In the beginning of every session a child climbs up on the trampoline, after which he sits and waits for the music therapist to be ready at the piano and start playing. What does he have to have experienced in order to do this? First of all his actions show that he is familiar with the

trampoline but also that he knows that his own actions and the therapist's actions are connected to each other somehow. Reversely, the music therapist's actions indicate that she knows what the boy expects and that she can be sure that he will wait for her – which is not a matter of course for these children!

Even though this example may seem commonplace, it shows a small 'practice', that has been built up from session to session and therefore contains a series of more or less implicit expectations between the partners. In this way, the practices are the 'local' context for interplay, because they make it possible for the partners to 'read' each other's expectations as pragmatically meaningful in the context.

Practices can be found at many levels in interplay. In my doctoral study I discovered a general practice form in music therapy with these children, which I have called the Interaction Theme (see Holck 2004 for an English presentation). Within each of the Interaction Themes one can find several 'practices' – some of them are obvious at first sight, others require micro analyses to be found and described explicitly.

WORKSHOP; FINDING 'PRACTICES'

In the following I will invite you to try to discover some of these 'practices' within a specific Interaction Theme, that I'll present below.

But first a brief explanation of the data collection and method of analysis used in my research. My investigation included five music therapists' individual work with six children in all. In order to analyse the interactions between child and therapist, I recorded their interplay with two cameras and edited the recordings subsequently, so that both the child and the therapist appear in the same frame. Then I first transcribed the auditory material and then the visual. After that I analysed the material horizontally and vertically. In the horizontal analysis, the material is divided into a series of episodes, which then are analysed parallel to the temporal axis in the material. In the vertical analysis the interactions are compared across the material, for the purpose of finding interaction patterns – or 'practices'.

Video clip:

'Michael' is a 5 year old retarded boy with atypical autism, and a vocabulary of ten words only. The Interaction Theme between him and the therapist consists of the following; Michael jumps on the trampoline to the therapist's piano accompaniment, after which she makes an (expected) 'sudden' break in the music. He stops jumping, and after a few seconds, she plays a little calling motif on the deep domi-

nant note. As he smiles, says “two” and starts jumping again, and the therapist ends the break by counting “one – two – three – now”.

Within this Interaction Theme, there are several practices that vary a little each time. As for example, when the therapist doesn’t start playing again after Michael’s first “two”, but looks at him teasingly. He smiles and repeats the word “two”, sometimes accompanied by an as-if jump on the trampoline.

These common ‘practices’ makes it possible for the therapist to vary her expressions and challenge the boy’s autistic need for sameness – in a way that he can manage within the structure, and that he enjoys!

CONCLUSION

Qualitative music therapy research is most often focused on constructed narratives told by informants being interviewed. In contrast, very little qualitative music therapy research is based on the observational approach described above. Aldridge (1996) has mentioned the ethnographic approach as useful for music therapists, but regarding music therapy research with clients without language, as far as I know no music therapists have used the approach described above. This is a shame, since I believe this research method to be very valuable in developing new concepts for describing music therapy interplay.

If the observed people can speak, Qualitative Observation Research can of course be combined with interviews after the process of analysis, for example as an expanded form of member check (Lincoln & Guba 1985). But the implicit character of many ‘practices’ makes it impossible to gather that kind of knowledge directly through interviews.

A famous example of combined observation (here both quantitative and qualitative methods) and interview comes from Stern, Hofer, Haft & Dore (1985), who investigated the *phenomenon* Affective Attunement. First they asked 10 mothers to play with their baby, while they were recorded on video. Afterwards Stern et al. viewed the recordings together with the mothers, and asked them to explain in their own words, what they were doing with their babies, and why.

This combination of video observation and interview is very useful in investigating new concepts. But interviews of the mothers right from the beginning would not have given much new knowledge, since Affective Attunement is pretty implicit as a phenomenon.

The same combination of observation (here purely qualitative) and interview (member check) was used when I found the general ‘practices’, which I have called Interaction Themes. The five music therapists included in the research would not have been able to point to this phenomenon, if I had asked them right away, but when they saw the different Interaction Themes presented together, they could give me a lot of feed back and comments to clarify my definition and delimitation of the phenomenon (Holck 2002, 2004).

The video analysis of 222 half-hour music therapy sessions - what did I learn?

Oldfield, Amelia

THE INVESTIGATION, GENERAL OVERVIEW

The general aim of this study was to find out more about my music therapy work with young children on the autistic spectrum and their parents. I wanted to confirm that my particular music therapy approach in this clinical area was effective and also to define this approach more specifically. This investigation was one of two music therapy outcome studies described in my PhD thesis (Oldfield 2004 and Oldfield *et al*, submitted).

I studied ten pre-school children on the autistic spectrum and their parents who received weekly, individual music therapy sessions over a period of 18 to 26 weeks each. The sessions were video-taped and all the videos were analysed in detail. The parents were interviewed and asked to fill in questionnaires both pre- and post-treatment. In addition, I took routine clinical notes after every session as well as writing the usual music therapy reports. These notes and reports were also included in the investigation.

I gained a great deal of important information from these notes and reports as well as from the interviews and questionnaires with the parents. In this presentation, however, I will focus specifically on the information I gained from the video-analysis.

THE VIDEO ANALYSIS

The research assistant, Emma Carter, videoed all the music therapy sessions. Once treatment with a particular child was over, she started to analyse the videotapes of

that particular child. She analysed the videos in random order, so that her possible expectations of progress would not influence her results. She analysed a total of 222 videos, which took her around 200 hours.

The video analysis system she used was the one that had been developed for my two previous music therapy research projects. (Oldfield and Adams 1995; Oldfield, Bunce and Adams, 2003).

For each of the children, the treatment objectives were translated into observable behaviours that could be counted and timed. These codes were then marked down in a time grid where every square represented five seconds. Important behaviours by the parents as well as by myself were also coded in a separate row of five-second time grids.

As the treatment objectives varied for each parent and child, the codes used for each dyad were different. Before starting analyses on a 'new' child the music therapy research assistant would meet with me to determine exactly what she should be looking out for and work out which codes she should use. Some codes, particularly those relating to the music therapist, were similar across all the children, others were only used for some of the children depending on what the specific aims for each child were.

I was aware that with only one camera some aims such as 'increasing eye contact' would not be possible to measure in a reliable way. Similarly, it was not always possible to gauge the child's eye direction towards myself or the parent as we all moved around and all three people were not always in the picture. However, I felt that there were enough behaviours that we could measure to be able to get some idea of how the child and the parent were progressing in the sessions.

To help her to keep track of time as she watched the video, the research assistant used an electronic metronome set at five beats to the bar, where a beat occurred every second. On every fifth beat a bell would sound indicating that she needed to move on to the next grid. The use of the metronome to help with video-analysis was developed by Bunce in my previous music therapy project with mothers and young children and had previously been a reliable and accurate way to gather data, (Oldfield, *et al*, 2003). The video analysis started at the same time for every child, on the 'lo' part of the first 'hello' in the music therapist's greeting song.

After the research assistant had analysed around fifteen videotapes the research consultant, Malcolm Adams, checked three different videotapes chosen at random to confirm agreement on the consistent use of the codes. After all the videotapes

had been analysed he randomly analysed two videotapes and found that he agreed with her results, indicating that her analyses had been reliable. Because of the experience gained using these methods in two previous investigations (Oldfield and Adams 1995, and Oldfield *et al* 2003) and also because of lack of time, it was not felt necessary to check inter-observer reliability in a more formal way.

The video analysis system developed by Plahl (2000) which she has called 'Kamuthe', has some similarities with the system I use here. However, her very detailed coding system is the same for all the children she analyses and is not tailored to the individual aims of the children. In her research project, she only analyses the first and the last five minutes of every thirty minute session. It is interesting to note that even though Plahl was able to use a computer programme to help with the video analyses, she still found that each minute she analysed took thirty minutes to complete. Although the music therapy research assistant did have to take additional time at the start of each new child to practise using the new codes, she then found that she could analyse each half-hour tape in one to one and a half hours.

Burford (1988) used video analyses to look at repetitive movements of children with profound learning disabilities and their carers. Recordings were made via a two camera system. The videos were analysed using an electronic time counter inserted on the screen to record real time to 1/100 second and frame by frame analysis. Unfortunately, this system would not have been viable for our analyses as we were trying to observe many different behaviours both for individual children and across the ten different experimental subjects. It was also unnecessary for us to time the behaviours we were analysing as accurately as in Burford's study.

INTERPRETING THE VIDEO ANALYSIS DATA

Once the music therapy research assistant had analysed all the videotapes, she and I counted all the codes for the children and the parents. This counting was very time consuming and took around half an hour per video. This meant that a total of around 110 hours was spent counting codes. These figures were then converted to percentages of total time codes recorded in each session in order to take account of the fact that each session varied in length. The percentages were subjected to statistical analysis.

In addition to counting up total numbers of each of the codes, I also counted up the length of some of the children's playing bouts in order to find out whether the amount of time children could focus on any one activity increased or decreased. I looked at the mean length of the playing bouts and the longest playing bouts for each of the sessions.

For the children and the parents I focused on how each of the behaviours we counted changed over time, because one of my hypotheses had been that I would be able to see such changes. When looking at the data on my behaviour in the sessions, I looked at mean percentages in order to get an idea of how I distributed my time and how this varied across the ten children.

RESULTS FROM THE VIDEO ANALYSIS

- Nine out of the ten dyads achieved some or all of individual aims set out before treatment began.
- Music therapy seemed to be particularly effective at increasing the children's levels of engagement. With a number of children, as the levels of engagement increased, the amount of playing and music making decreased.
- Music therapy was also good at increasing some of the children's use of words and reducing echolalic speech or vocalisations.
- For the three children who had difficulties managing their behaviour, music therapy did not reduce the children's amount of negative behaviours. However, these three children all had a honeymoon period at the beginning of treatment when they showed very few or no negative behaviours.
- A study of the way I spent my time in music therapy sessions revealed that I was generally very active. The amount of time I was 'not playing or attempting to engage' was small (average of 12%) and was similar for most of the children.
- I spent a high proportion of my time vocalising.
- I played the clarinet for similar amounts of time with each of the children. However, the amount of 'playful movement' varied more from child to child.

CONCLUSION

These were very positive and interesting results. When combined with the information from my music therapy notes and reports as well as the parents questionnaires and interviews, my findings confirmed that the work that I was doing was effective. I also gained some new insights into the work that I was doing and was therefore better able to describe and define my particular approach with this client group.

When I first set up this investigation, I had also hoped to be able to look in detail at how what I did as a music therapist in the session affected the child's responses. Unfortunately, because of the huge amount of data we had to analyse I did not have time to do this. This meant that some aims such as 'increasing turn taking' or 'encouraging imitation' could not be evaluated specifically in this thesis. However, in the future, the clinical psychologist, Malcolm Adams, and I, hope to find some

more funding to enter all the video analysis data (and not just total codes and length of bouts as we have done at present) into the computer. We would then aim to devise a special computer programme to analyse how each of the children's individual actions correlated with my actions, or those of their parents.

Video Micro Analysis – quantitative and qualitative aspects

Plahl, Christine

BACKGROUND

Music is known to have a potential of establishing preverbal emotional and social communication and music therapy successfully uses this potential for establishing a musical contact and developing a musical dialogue.

AIMS

To evaluate how and to what degree music is able to foster the development of preverbal social-emotional communication of multiple handicapped children – this means to evaluate both the effect of the music therapy treatment and to analyse the process of the music therapy treatment – I conducted a clinical intervention study in the Centre for Social Paediatrics in Munich, Germany. 12 multiple handicapped children, aged 2 to 6 years – with a developmental age from 8 to 32 months – received a two phase music therapy treatment comprising 10 sessions.

The focus of the analysis has been on the preverbal communication through joint attention, turn taking and intentional reference. Criteria for the outcome evaluation – which represent quantitative aspects – have been structural parameters of preverbal communicative abilities like frequencies and percentages of joint attention, turn taking and intentional reference. For the process evaluation of the music therapy sessions – representing the qualitative aspects – the interaction of child and music therapist has been analyzed for fostering communicative patterns – thus identifying those behavioural and musical aspects that create a zone of proximal development (Vygotsky, 1978).

METHOD

There has been a multi-method research design with a detailed micro analysis of music therapy video tapes by a computerized category system. Additionally the

music therapists gave their estimation of experienced contact, emotional state and communicative activity on a rating scale completed after each music therapy session. The status of preverbal communicative development has been tested at the beginning and at the end of each treatment by the Early Social Communication Scales (ESCS) (Seibert & Hogan, 1982). In a semi-structured interview the parents reported the children's communicative development at home.

All music therapy sessions have been videotaped and for the computerized microanalysis of music therapy sessions a category system has been developed. This category system is called KAMUTHE which means 'Category System for Music Therapy' and consists of four categories for the analysis of the child's behavior and three categories for the analysis of the music therapist's behavior (Plahl, 2000). The communicative behavior of the child is categorized into gaze, musical activity, vocalizations and gestures. The behavior of the music therapist is categorized into musical, verbal and nonverbal communicative behavior. To achieve a differentiated behavior analysis the technique of real time event coding has been used. From each session the first and the last five minutes have been selected for both comparing the beginning and the end of each session and the course of the whole treatment.

RESULTS

The results show significant improvements in the ability of preverbal social-emotional communication. This has been demonstrated for all kind of data and is especially impressive for the ability to regulate emotion and behaviour. Here all children developed more intentionality, more intensity and more self-confidence. The studied children improved their basic preverbal communicative competences: shared attention and behaviour regulation - the two dimensions of the ESCS. The figure shows the mean scores for the treatment group, that increase significantly on the 0.01 level in between one treatment phase and in the course of the whole treatment (Plahl & Voigt submitted).

The video micro analysis revealed that the observed frequencies in the communicative modalities of gestures, vocalizations, and activities with music instruments increase significantly at the 0.1 level comparing the beginning and the end of each session both for the first and for the second treatment phase.

The most important finding, however, is the growing percentage of intentional communication. Intentional communicative acts are defined as all communicative activities on musical instruments that are followed by a gaze to the music therapist - thus signalling communicative reference after a communicative contribution. The

figure shows the clear decrease of non intentional communication combined with a simultaneous significant increase of intentional communication.

The results of the study show, that the examined children significantly improved their ability to express their needs and desires, to regulate their own emotions and the behaviour of their social partners in a more intentional and therefore more effective way and to gain by this way more self-confidence, independence, and more intense relationships to other persons. This not only helps to prevent secondary disorders caused by deficits in communicative competences but represents an improvement of living quality for the multiple handicapped children as well as for their parents and other relating persons.

WORKSHOP

The interesting question now is how these results can be explained and how they are created in the course of the music therapy treatment.

The details of the video micro analysis reveal how the music therapist creates the fostering musical environment. This special feature of interaction is called zone of proximal development by Vygotsky (1978) and is characterised by a specific set of musical activities and a special form of therapeutic co-regulation that enables the child to perform activities that would not be possible without this specific structuring and enabling frame of musical interaction.

Example 1: The figure shows the result of the interaction analysis of a dance where the music therapist is creating a specific frame of coherence: She is accompanying her own dancing with a song, she is praising the child after each dance session, and she is asking her before the next session if she wants a repetition. The child, a four year old girl with Cornelia-de-Lange-Syndrome, who is not able to use language for communication, obviously is expecting the question and is signalling her wish for repetition by a gesture that is referring to the music therapist.

These interactions are characterized through a coherent pattern of child and therapist communications, which means they provide a situation that is structuring an enabling frame for the social and emotional regulation of the child.

Example 2: In the following figure three patterns of synchronizing can be revealed: First the music therapist is accompanying the child's play on the guitar by a song. Then the music therapist is playing herself the guitar and the child is gesturing her wish to have the guitar again. Finally the gaze of the child to the therapist is responded by the confirming gesture of nodding her head.

It is this responding structure of the music therapist's behaviour – in rhythmically accompanying and answering the child – that not only creates a fostering frame but also reinforces the child through synchronized resonance.

Example 3: A still more detailed analysis of reciprocities reveals the elements of a musical dialogue. This figure shows the interaction pattern of a sequence from the ninth session with a five year old autistic boy. The communication pattern of this sequence clearly demonstrates a dialogical structure. The boy is signalling his communicative reference by directing his gaze to the hands of the music therapist after finishing his contribution.

This musical dialogue is characterized by reciprocal turn taking, that is very well tuned and by musical contributions, that are shaped both by the own preceding contribution and the contribution of the partner.

CONCLUSIONS

The analyzed interaction patterns of different music therapy sequences are characterized by an impressive pattern of coherence, symmetry and reciprocity. Rhythmic changes in the communicative behaviour of the music therapist facilitate joint attention and reciprocal reference. Synchronicity created by several musical and behavioural means allows for resonating actions and affections of the child. Finally reciprocity in the communication of music therapist and child enables a mutual exchange of turn taking – the ground for behavioural and social regulation.

Music can be understood as a transforming co-constructed process between two or more persons or as a transforming constructed process in one person. To support this transforming effect and to succeed in fostering the social emotional communication of multiple handicapped children the music therapy context has to be characterized by 'good' coordinated interactions (Tronick, 1989).

This kind of musical context enables the child to move frequently from affectively positive, mutually coordinated states to affectively negative not coordinated states and back again and is thus providing a central condition for therapeutic change. A specific mixture of repetition and variance in musical patterns combined with elements of recognition and surprise in the musical dialogue motivates the child for emotional expression and social behaviour regulation.

The combination of both quantitative and qualitative aspects of video micro analysis in music therapy research demonstrates that music therapy is successful in fostering preverbal development and can provide more insight in the process of how development is fostered through music.

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CHAPTER 29

*Integration of different music
therapy concepts in the field of
Neurology/ Neurorehabilitation: Pie*

*in the sky or urgent
need?*

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Abstract:

Following a research study, which is concerned with the evaluation of music therapy in German neurorehabilitation centers, it will be discussed, where the future position of music therapy within neurorehabilitation could be. After a short summary over American, Australian and European music therapy concepts within this field which are concentrating on physical, sensorial, cognitive, communicative, social and emotional aspects it will be attempted to give a synopsis of functional as well as of psychotherapeutic oriented indications, goals and techniques. If the improvement of the patient's life quality is to be seen as a common goal, the treatment following only one aspect of the normally simultaneously damaged aspects, might miss the patient's needs. Only, if therapeutic interventions are adapting flexibly to the changing needs of the patient, he and not a frame of concept is actually in the centre of concern.

If functional training will be combined with emotional and communicative / relational approaches, ethical questions have to be discussed. The therapeutic attitude of psychodynamic psychotherapy-methods, under which music therapy is subsumed, will be of utmost importance for this integrated therapeutic approach.

KEYWORDS:

Music Therapy, Neurorehabilitation, Sensorimotor Training, Cognitive Stimulation, Coping, Emotional Stabilisation

Music therapy within a multidisciplinary medical team

Music therapists being identified with an psychotherapeutic approach, might have problems positioning themselves in the area of medically oriented neurological rehabilitation. Their focus are on emotions and communication as well as on working on relationships inside or outside the musical area. Somatic-medical oriented staff, however, concentrate more on the body and its functions. Their medical view focuses primarily on the physical functions and might regard the psyche rather as a nuisance element within the treatment process. Therefore, physical symptoms tend

to be regarded on a physical level although they often stem from psychological causes.

On the other hand, psychotherapeutic oriented music therapists can underestimate the value of a properly functioning body and how much quality of life depends on this. In this context, one has to consider the term of “somatisation” which might include a tendency towards derogative interpretation of physical symptoms. Psychotherapists tend to ignore the fact that functioning anatomical ducts are the prerequisite for any facial play, gestures, eye contact or vocal expression. Damasio states in his book “The feeling of what happens” the obligate body-relatedness of feeling: “The current evidence suggests that most feelings probably rely on all sources – skeletal and visceral changes as well as changes in internal milieu” (Damasio 1999, p. 288).

The ability to move or to direct muscles intentionally is the basis for emotional expression and communication as well as for mobility. Motor disturbance entails not only emotional disorders but also affects facial expression, speech, cognition, social-communicative abilities, sensory perception, the degree of consciousness, as well as ingestion. The functioning of the sensory motor system is therefore the basis of participation in every day life. *Self-determination is extensively dependent on a functioning body. The extent of self-determination is an essential part of the quality of life. Therefore quality of life is definitely based on mobility.*

In Germany a study revealed, that 29% of all german Neuroreha-centres have already integrated music therapy into their programs (Pöpel , Jochims, van Kampen & Grehl 2001, p.1492). One of the topics being questioned was the comparison of music therapists' and senior consultants' views on the indication criteria for music therapy. It shows therapists targeting coping skills, emotional stability, interaction and the regulation of autonomous dysfunctions (Pöpel, Jochims, van Kampen & Grehl, p. 1499f). Their primary objectives are not concerned with the treatment of cognitive, motor or sensory functional deficits.

Senior consultants , by contrast, value the importance of music therapy intervention exactly in the areas of cognitive, motor and sensorial deficits without disregarding emotional interactive indications. Obviously therapists' and doctors' objectives in music therapy differ considerably. There is need of clarification. *Clearly, for the medical staff, music therapy is considered a connecting link between the different approaches to medical and psychological treatment.* It is important to underline that the treatment approach on the emotional level is not questioned by the medical side. *Rather, it is the indication catalogue of music therapists that needs expanding.*

Concepts of music therapy in neurological rehabilitation

From the European point of view the deciding factor when comparing diverse approaches, is the inclusion of functional deficits into the techniques of music therapeutic treatment. Concerning the treatment of functional deficits, a valuable approach is offered in the United States with their longstanding tradition of incorporating music therapy into neurological rehabilitation. M. Thaut calls his concept “Neurological music therapy” (Thaut 1999) and gives following basic definitions:

- “Neurological music therapy is defined as the therapeutic application of music to cognitive, sensory and motor dysfunctions due to neurologic disease of the human nervous system.
- Neurologic music therapy is based on a neuroscience model of music perception and production and the influence of music on functional changes in nonmusical brain and behavior functions.
- Treatment techniques in neurologic music therapy are based on scientific research and are directed towards functional therapeutic goals.
- Treatment techniques are standardized and applied to therapy as Therapeutic Music Interventions (TMI) which are adaptable to the patient’s needs.
- In addition to music therapy training, neurologic music therapists are educated in the areas of neuroanatomy / physiology, brain pathologies, medical terminology, and rehabilitation of cognitive and/or motor functions

The focus of this concept is the recovery of functional abilities including sensory and cognitive abilities. Communicative, social and emotional aspects are excluded deliberately.

C. Tomaino’s concept (Tomaino 2001, 2002) concentrates on cognitive stimulation, aspects of attention, powers of recollection, as well as the connection to the “self”. “There is a strong connection between the auditory system and the limbic system. This biological link makes it possible for sound to be processed almost immediately by the areas of the brain that are associated with long-term memory and the emotions. Because processing occurs and/or is mediated at a subcortical level, some information processing is possible despite higher cortical damage. This is evidenced clinically by the strong emotional responses to familiar music we observe in persons with memory deficits, such as traumatic brain injury, multi-infarct-dementia or Alzheimer’s disease. Familiar songs become a tool for connecting to seemingly lost parts of the personality by providing a necessary link to the “self”

(Tomaino 2001, p.2). On the indication list for music therapy within neurology she puts:

“Memory deficits, depression, balance/gait problems, fine motor problems, agitation /aggressive behaviours, acute or chronic pain, poor attention, decreased vocal projection, expressive aphasia, poor motivation, reduced muscle strength..” (Tomaino 2001, p. 1).

Listed are: cognitive, emotional, functional, communicative problems. Not on the list are sensorial deficits as for instance perception disorders or aschematia.

D. Berger (Berger 1999, 2002) emphasises the sensory integration into a perception training, which in turn, is meant to lead to behavioural changes. In her concept, she concentrates on sensory problems, while mood and emotional problems are considered mere side effects.

“When the system is not properly interpreting information from the environment, it cannot adapt satisfactorily. Adequate sensory information processing is important for functional adaptation. And functional adaptation is crucial for survival. Music therapy, dependent on auditory processing in conjunction with overall sensory function, must concern itself with the impact of these dysfunctions if goals for healing and betterment are to be successfully achieved” (Berger 2002, p. 171).

As a conclusion one can say: *American music therapy regarding neurological rehabilitation is largely oriented towards function.*

This opposes European concepts, which prioritise differently. The Nordoff-Robbins school focuses on stimulation of communication with the objectives of contact and (musical) relationship (Gustorff & Hannich 2000; Gustorff 2001). Reflections about sensory perception, as well as, cognitive stimulation are included in D. Gustorff's concept, not as a main objective of music therapy intervention but rather as a side effect. W. Magee, who deals mainly with progressive disorders as Huntington's disease or MS, defines her objective as to offer alternative forms of expression as well as stimulation of communication skills (Magee 1995, 1999; Davis & Magee 2001). Both use the technique of free improvised music arising out of the patient's actual situation. However, memory deficits are not patched by the improvised music as it is with familiar songs and cognitive deficits therefore go untreated.

Gilbertson and Ischebeck include in their concept communication problems, problems of movement co-ordination, cognitive problems, dysfunctions of body awareness, as well as, problems of social integration. Affective and emotional problems are not listed (Gilbertson, Ischebeck 2002).

In the author's previous articles, her goals deal with the emotional aspects of chronic disease, as well as, reconstruction of the "self" function. "Cerebral lesion affect the organ required for coping with disease. It is possible to establish contact with the intact "inner self" of the cerebral reduced patient via a preverbal medium remaining on a concretely active level. This offers a chance to achieve emotional coping with disease even if the cognitive faculties are restricted" (Jochims 1995, p. 29). "To achieve socialisation, the patient needs an anxiety-free experience of two separate individuals inter-relating, so that their own identity and inner autonomy can grow. The intra psychological perception of "I am" becomes the inter psychological "relating-to-each-other". The separation of "I" and "you" is the next step of maturation. In a musical relationship, this can be symbolised by the different sounds created by therapist and client or by reciprocal patterns of music. The symbiosis, symbolised musically by interwoven, non-differential sounds, should be dissolved delicately and through dialogue structures. This leads to the experience of two separate persons communicating" (Jochims 1997, p. 148). In this concept any considerations regarding functional goals is missing.

While M. de Bruijn emphasised, when starting music therapy within neuro rehabilitation, in accordance with the European tradition on the social, communicative and emotional aspects of music therapy (de Bruijn, 1994), the Australian colleague L. Forrest – specially working with progressive neurologic diseases – changed her point of view from mere emotional oriented goals to a combination of physical and psycho-social objectives." In conjunction with these (i.e. pharmacological and physical) interventions, music therapy is increasingly being found to be affective in addressing both the physical symptoms and the associated psycho-social and emotional issues that may arise for patients who have MMND" (Forrest 2002).

CONCLUSION

European and partly Australian music therapy tradition emphasises communicative and emotional indication criteria but largely neglects aspects of functional deficit treatment.

In this context, the aspect of transferring music therapeutic treatment results into relevant every day situations needs to be discussed. In the author's opinion, the improvement for instance of the patients' communication abilities can not be confined exclusively to music therapy sessions, as this promotes dependence on the therapist and is therefore questionable within itself. *The treatment results have to be transferable to the patient's overall situation.* Only then health insurance coverage of therapy expenses will be justified. In this context, one has to bear in mind that 70% of hospitals who do not have integrated music therapy into their program are interested to do so, if they only could find the financial means (see Pöpel, Jochims,

van Kampen & Grehl ,p. 1495). *The health insurance system is only willing to pay, if progress in daily life is seen. That should start us thinking.*

The patient in the centre

If treatment is based on a single concept, the question remains open whether the patient's needs are fully met. The patient's main aim can only ever be to improve the quality of life. If he has to adapt to a concept that considers only one aspect of his many dysfunctions, there might be the danger of the treatment missing his real needs completely. To focus on the patient's need for improved quality of life, might mean that the therapist has to subordinate his own identity as functional or cognitive, emotional or communicative oriented therapist, to that of his patient's. For example, a paralysed person naturally suffers psychologically, because she is unable to move. Wouldn't a music therapist help her more by offering active play, which incorporates mobility training and sensory integration instead of focusing on the suffering itself? All aspects of the patient's dysfunctions are likely to be disturbed at the same time, but every aspect has a time of being central for him. *To be alert to the patient's signals and put them into context with their overall personal situation, demands flexibility from the medical team.* They must adjust the treatment objectives to the patient's needs and not the other way round. *„The psychotherapeutic approach that regards stimulation of mobility, as well as, mobility and perception training, as less important than the patient's psychological needs must be reconsidered. The same applies to the purely scientific approach regarding communicative, emotional, cognitive and social aspects as irrelevant (see Thaut 2004).* Only when we are able to accept and treat all those aspects on an equal basis will we fulfil the patient's wish for higher quality of life.

Many patients never reach the stage where it is possible to deal with their illness emotionally. They therefore are unlikely to capture the interest of psychotherapeutic oriented music therapists, and consequently are never treated by them. If one changes the approach, but not the medium, music therapy is a fantastic and very helpful medium, for instance, to start or co-ordinate movement; as M. Thaut describes (Thaut 1996). Actively played music, or clapping hands along to music could be a pleasurable way to train intentional hand movement in the case of apraxia, as C. Elefant demonstrates this in her touching video of music therapy with Rett Syndrome patients (Elefant 2001). The deciding point for the therapist is to perceive the complex actual needs of the patient with all their dysfunctions and incorporate them into the treatment. An obvious example would be a situation of a patient with good mobility, but suffering of complete disorientation: he would not

gain much if he would given further mobility training enabling him to walk without help. Due to the disorientation he would be in danger of falling down stairs, taking off into the street etc. In consequence, he might get referred into a psychiatric ward, without doubt the wrong place that would destabilise him psychologically even further. Physical therapists sometimes tend to stick to their functional training concept instead of giving priority to orientation training, which would help patients to perceive their real surroundings. What use is it for a patient to be able to walk on his own volition if he at the same time must be fixated for his own safety or being sent to a closed psychiatric ward?

Another example of strictness is the concept of resource or deficit orientation. During therapy I myself usually like to start with a movement resource. This might give the patient the feedback of “I sound therefore I am”, which would contribute to building identity. On the level of body awareness it might give the feedback of “I have a hand - this is my hand”. And thirdly, the self confidence might be strengthened by the experience of “I can do something”. However, if I remain with the movement resource for too long, I might neglect the patient's need for recovery of his body awareness, for instance of the neglected side . Conversely, those therapists working exclusively deficit-oriented might be in danger of demoralising the patient, which might lead to manifest withdrawal in the end (see Jochims 1995). Again the question remains, whether we are flexible or even qualified enough to adjust our interventions to the patient's needs. This would mean that *music therapists must be able to switch between experience-oriented therapy suitable to certain phases and exercise-centred therapy suitable to other phases..*

Synopsis of different music therapy concepts

The music therapist needs to bring together all existing concepts of functional and psychotherapeutic treatment to be able to respond to all aspects of brain damage, despite the clear dividing line between the approaches. A synopsis of indication , goals and techniques in all six aspects of damage gives an overview.

TABLE 1. Motor function

| Indication | Goal | Technique |
|--|-----------------------------------|--|
| Motionlessness | Motor stimulation | <ul style="list-style-type: none"> • Rhythmic-acoustic stimulation • Led movements on instruments • Movement songs with words • Movement songs without words • Throwing a ball in a drum(triggering the anger) |
| Impairment of movement coordination (extremities) | Motor coordination | <ul style="list-style-type: none"> • Rhythmic acoustic stimulation to movement • Musical activity on instruments • Keeping fist or stretched hand to led movements • Translating auditive impression into movement (tempo, dynamic) |
| Impairment of movement coordination (eyes, head) | Promotion of visual mobility | <ul style="list-style-type: none"> • Games with movement register • Various instruments being played on demand • Movement songs for the head |
| Reduced muscle strength (extremities, head position) | Reconstruction of muscle strength | <ul style="list-style-type: none"> • Playing on high hanging instruments • Operating a cassette recorder by the head through a button |

TABLE 1. Motor function

| | | |
|---|--|--|
| Reduced voice function (dysarthrophonia) | Promotion of movements of jaw, vocal cord, tongue, lips Breathing coordination | <ul style="list-style-type: none">• Singing familiar songs• Movement songs• Antiphonal singing• Play on wind instruments |
| Speech apraxia | Promotion of purposeful movements of tongue, vocal cord, jaw | <ul style="list-style-type: none">• Behaving like an actor: showing mimic expression while affective improvisation is going on |
| Buccofacial apraxia | Promotion of purposeful movements of facial muscles | <ul style="list-style-type: none">• Antiphonal singing with different mimic expression• Movement songs for lips, jaw,, eyebrows, nose• Play on wind instruments with higher blowing pressure |

TABLE 2. Sensory perception

| Indication | Goals | Technique |
|---|------------------------------------|--|
| Central auditive processing disorder (concerning attention, storing and sequencing, localisation, discrimination, selection, analysis, synthesis) | Improvement of auditive processing | <ul style="list-style-type: none">• Listening exercises : differentiation of dynamics, tempo, emotional expression (inter alia)• Auditive enrichment of acoustic stimuli• Imitating of tempo- and dynamic variations• Imitating rhythms without visual contact• Changing tempo or dynamics or other musical parameters in joint musical activities• Marking the end of a song• Relating visual symbols or words to auditive impression |

TABLE 2. Sensory perception

| Indication | Goals | Technique |
|---|---|--|
| Aschematia (Autotopagnosia, finger agnosia, somatosensory deficits) | Promotion of somato-sensory consciousness | <ul style="list-style-type: none"> • Led movements on instruments (hand, arm) • Led movements on instruments with stick • Led movements on instruments (foot, leg) • Squeeze a sound-ball • Picking on guitar or lyre • On demand bending or stretching fingers separately on a drum • On demand keep fist or stretched hand on a drum • Rocking the upper part of the body to music/ lullabies/free improvisation |
| Sensory understimulation | Enrichment of sensory inputs | <ul style="list-style-type: none"> • Listening to music • Actively playing on instruments • Listening to sounds in nature • Leading to tactile, acoustic, visual and vestibular impressions • To see to more diversion on the ward |

TABLE 2. Sensory perception

| Indication | Goals | Technique |
|---|---|--|
| Aschematia (Autotopagnosia, finger agnosia, somatosensory deficits) | Promotion of somato-sensory consciousness | <ul style="list-style-type: none"> • Leded movements on instruments (hand, arm) • Leded movements on instruments with stick • Leded movements on instruments (foot, leg) • Squeeze a sound-ball • Picking on guitar or lyre • On demand bending or stretching fingers separately on a drum • On demand keep fist or stretched hand on a drum • Rocking the upper part of the body to music/ lullabies/free improvisation |
| Sensory overstimulation (aggressiveness, irritability) | Sensory integration of tactile, acoustic, visual and vestibular stimuli | <ul style="list-style-type: none"> • Actively playing on instruments • Experience of quietness and silence |

TABLE 3. Social competence

| Indication | Goal | Technique |
|--|--|---|
| Visual impairment of object-perception (hand/eye coordination) | Object constancy | <ul style="list-style-type: none">• Combining hand and eyes when playing• Visual training with movement registerer |
| impaired auditive attention | Improvement of active preparedness for listening | <ul style="list-style-type: none">• Listening exercises• Exercises in imitating rhythms, tempo, dynamics...• Hearing exercises without visual contact• Stimulation of auditive reactions within musical activity |

TABLE 3. Social competence

| Indication | Goal | Technique |
|-----------------------------------|--|---|
| Inhibited interactional behaviour | Perception of the interpersonal sphere | <ul style="list-style-type: none"> • Imitation of mimic expression of therapist • Naming the mimic expression of therapist • Imitating speech sound of therapist • Naming speech sound of therapist |
| | Stimulation of resonance-capability | <ul style="list-style-type: none"> • Joint improvisation structured like a dialogue focusing on referring to each other |
| | Stimulation of signaling behaviour | <ul style="list-style-type: none"> • Joint improvisation structured like a dialogue focusing on initiating |
| | Improving the self-awareness within the interpersonal sphere | <ul style="list-style-type: none"> • Recetative singing, mirroring all actions as well as mimic expression |
| Social retreat | Improvement of interactive abilities Opening up for joie de vivre | <ul style="list-style-type: none"> • Interactive improvisation • Going out for a concert, theatre, stroll through town • Listening to nature sounds |

TABLE 3. Social competence

| Indication | Goal | Technique |
|--------------------------|---|--|
| Antisocial behaviour | Broadening of interpersonal perception + ability to act | <ul style="list-style-type: none"> • Interactive improvisation • Giving responsibility to the patient for the ongoing improvisation (marking the beginning of the bar; filling rests; therapist stopping, if the patient does not fulfill his musical duty..) |
| | Sensorial integration | <ul style="list-style-type: none"> • See „sensory perception“ |
| Imminent hospitalism | Prevention of hospitalism | <ul style="list-style-type: none"> • Joint actions: concert visit, theatre... |
| Maligne regression | Reduction of regression | <ul style="list-style-type: none"> • Interactive improvisation • Drumming • Giving responsibility to the patient for the ongoing improvisation |
| Psychotic decompensation | Reconnection to reality | <ul style="list-style-type: none"> • Drumming • Joint actions: cooking, planting etc... |

TABLE 4. Emotion

| Indication | Goal | Technique |
|-------------------------------|--------------------------------------|---|
| Condition of Tension | Reduction of tension | <ul style="list-style-type: none">• Singing familiar, emotional positive reminding songs to the p. |
| Conditions of trust | Reduction of distrust | <ul style="list-style-type: none">• Ritual of Hello - and Goodbye songs |
| Emotional instability | Emotional stabilisation | <ul style="list-style-type: none">• Active improvisation• Active playing to familiar songs |
| lack of drive | emotional stimulation | <ul style="list-style-type: none">• Active musical activity• Singing familiar songs together |
| Inhibited emotional responses | stimulation of emotional sensitivity | <ul style="list-style-type: none">• Active improvisation• Listening to previously loved music• Singing familiar songs |

TABLE 4. Emotion

| Indication | Goal | Technique |
|--------------------------------|--|---|
| reactive depression | action orientated working on conflict | <ul style="list-style-type: none"> • Active improvisation • Emotional mirroring • Acting for the patient in emotional expr. • Composing songs with patient • Throwing a ball on a drum/ gong • Relation of auditive impressions of state • of moods to own current state of • feeling • Leading the movements of the patient |
| Deny of illness (Anosognosia) | evoking emotional responses | <ul style="list-style-type: none"> • emotional acoustic stimulation |
| defense of emotion | leading to emotion | <ul style="list-style-type: none"> • Focusing on musical parameters instead on feelings |
| lack of self confidence | improvement of self esteem | <ul style="list-style-type: none"> • working with resources of the patient |
| fixation to pain | distraction of pain | <ul style="list-style-type: none"> • combination with physiotherap. or O.T. |
| imminent hospitalism | prevention of hospitalism | <ul style="list-style-type: none"> • attending a concert, visiting town, ... |
| lack of motivation for therapy | discovery of new life goals and -qualities | <ul style="list-style-type: none"> • Discovering resources (music!) • Planning the future |

TABLE 4. Emotion

| Indication | Goal | Technique |
|-------------------|--|--|
| agitation | improvement of self-awareness | <ul style="list-style-type: none"> • movement against instruments |
| prosopagnosia | establishing an emotional relationship | <ul style="list-style-type: none"> • taping of the sessions to take them home |

TABLE 5.

| Indication | Goal | Technique |
|---|---|---|
| disturbed vigilance | improvement of vigilance, alertness and attention | <ul style="list-style-type: none"> • Singing familiar songs to the patient (lullabies, christmas songs) • Improvised singing to the breathing rhythm of the patient |
| Speechlessness (acinetism?, aphasia? , speech apraxia?) | Initiation of non-verbal communication | <ul style="list-style-type: none"> • Singing familiar songs to the patient + leaded movement on drum • Sound accompaniment to spontaneous movements • Musical structure with rests to be filled by the patient • Antiphonal singing |
| Reduced ability for dialogue (speech apraxia, aphasia) | Development from preverbal to verbal expression | <ul style="list-style-type: none"> • Translating sounds into words by augmentative communication aids |
| | Reconstruction of basic abilities for dialogue | <ul style="list-style-type: none"> • Imitating, initiating, turn taking with rhythms or in free improvisation |

TABLE 5.

| Indication | Goal | Technique |
|--|--|--|
| Inhibited facial expression (buccofacial apraxie) | Improvement of facial expression | <ul style="list-style-type: none">• Movement songs for the training of facial muscles• Training of mimics by auditive stimulation of emotional expression |
| Impairment of speech pro- duction (dysarthrophonia) | Improvement of vocal and speech abilities | <ul style="list-style-type: none">• Melodic intonation• Vocal intonation• Singing familiar songs |

TABLE 6. Cognition

| Indication | Goal | Technique |
|--|---|---|
| Impaired consciousness | Improvement of vigilance, alertness and attentiveness Reconstruction of memory | <ul style="list-style-type: none"> • Singing lullabies to the patient • Singing christmas songs to the patient • Singing songs to the patient, triggering positive emotional responses in connection with his former life • |
| Impaired orientation (person, time, situation) | Redevelopment of identity Establishing orientation | <ul style="list-style-type: none"> • Musical activities on instruments • Beating the pulse to familiar songs • Mirroring the activities of the patient by recitative singing • Changing tempo if the patient changes tempo • Changing dynamics if the patient changes dynamics • Singing seasonal songs • Keeping a time structuring diary |
| Lack of awareness of neglect | Reduction of neglect | <ul style="list-style-type: none"> • Positioning instruments to play on the neglected side |

TABLE 6. Cognition

| Indication | Goal | Technique |
|--|---|---|
| Lack of insight in illness | Improvement of insight in illness | <ul style="list-style-type: none">• Emotional enrichment of stimuli |
| Impaired attention span (auditive, visual) | Improvement of attention (auditive, visual) | <ul style="list-style-type: none">• Imitating rhythms, beginning with one bar, extending to four bars• Following changes in dynamics, tempo or... of therapists music• Hearing exercises• Giving spaces in songs for response• Imitating changing numbers of beats• Assignment of words to auditive impressions• Exercises with movement registerer |

TABLE 6. Cognition

| Indication | Goal | Technique |
|-----------------------------|-----------------------------------|--|
| Impaired concentration span | Improvement of concentration span | <ul style="list-style-type: none">• Combining movement and listening• Ending together with the therapist• Initiating rhythms• Suspending the length of musical activity in songs• Suspending the rhythms to be imitated• Summing by playing• Response to a special effect in a song (leaving out a beat, doing one beat on a different instrument....)• |
| Retrograde amnesia | Improvement of memory performance | <ul style="list-style-type: none">• Singing together important life-historic songs |

TABLE 6. Cognition

| Indication | Goal | Technique |
|---|--|---|
| Lack of drive (impairment of executive functions) | Improvement of drive Initiating complex actions | <ul style="list-style-type: none"> • Singing and playing familiar songs • Free improvisation on instruments, with voice • Fixing the order of instruments to be played • Action songs |
| Apraxia | Improvement of purposeful movements | <ul style="list-style-type: none"> • Learning the handling of an instrument • Coordinating movement to a given, slow pulse • On demand performing different dynamics, movement tempo..... • Translating auditive impression into movement • On demand performing different types of movement (wiping, tapping, beating, ...) |

UNDERLYING IMAGE OF MAN

The underlying image of man needs to be reconsidered when the primarily psychotherapeutic- oriented music therapy concept is enlarged by the dimension of exercise treatment of functional, sensory and cognitive deficits. Performance-oriented therapy techniques, be they of medical or psychotherapeutic nature, are based on a more mechanical image of man. Experience-oriented methods as humanistic and psychoanalytic schools emphasise the dimension of depth. Is this sharp differentiation really helpful in the treatment of patients? If one wants to support the patient in his objective for a better quality of life, one needs both approaches. *People need*

achievement as incentive to be able to develop. People unable to achieve development nevertheless need affection, love, empathy, and the feeling of approval.

Neurological rehabilitation is an area that clearly shows the lack of a conceptual image of man for those people who are unable to change: be it in a functional, emotional, communicative or interactive area. How do therapists communicate and sympathise with someone unable to develop any further? Do they accept these patients as part of our society, as entitled to the same affection and love as somebody able to perform? The German health insurance system for instance is only willing to pay for documented progress. This reveals quite a different way of thinking. In the author's opinion, stopping payment when there is no definite therapy result expresses the non-acceptance of a human being in their actual state.

The problem of accepting people who are unable to develop arises everywhere, for instance as well in the field of psychiatry. This is a problem not confined specially to the area of achievement-oriented treatment but a basic ethical one, concerning society as a whole (Jochims 2000 a, 2000b). On the other hand: even the members of a medical or therapeutic team need to see minimal progress on the part of the patient in order to feel the inner power to continue with the treatment. Actually, it is easy to fall into a depressed state as a therapist, when our efforts do not yield any progress. The needs of the team members occasionally might impede openness towards and acceptance of non-developing patients. At our hospital, for instance, physiotherapists and occupational therapists change wards every half year. They leave the chronic wards because they cannot bear the never-changing state of the patients. Fortunately, these problems are being dealt with openly. Nevertheless, there is a lot feelings of guilt on part of the staff. Others stay with the patients for years but suffer from depression that sometimes turns into underlying aggression towards the patients. *There exists, in the area of neurological rehabilitation, the real danger that patients who, for instance, remain in a vegetative state, won't get enough attention, won't raise any interests, or will be forgotten.*

Discussion

The link connecting achievement-oriented exercise treatment aiming for improvement of functional deficits and psychotherapeutic treatment, is the emotionally stable relationship between patient and therapist. A therapist able to hold and endure, to challenge and demand at the same time, to support and confront, and able to catch the patient's signals - D. Stern speaks of "affect attunement" (Stern 1985)- will be able to decide where to set focus when meeting the patient. The objectives

have to be adjusted every day to the patients changing needs regarding personal growth and quality of life. The therapist must communicate important messages to the patients, such as “I like you”, “I can give you security”, “You are ok as you are”, “You are important to me”, “You are part of this world and therefore you also carry responsibility”. These messages symbolise a sound relationship, supervision based on responsibility, respect of the uniqueness of the individual, encouragement and acknowledgement of the patient’s effort and achievement, the necessity of again taking up responsibility in a social context.

Focusing exclusively on deficit training strains the relationship. An exclusive focus on emotional support or on communication might be interpreted as “it doesn't matter if I make an effort and can actually achieve something”. If the therapist only acts encouragingly towards the patient and avoids any confrontational situations this might result in the patient being referred to the psychiatric ward. Yet, merely acting confrontational without giving encouragement might cause the loss of the patient's self-confidence. *It is a matter of getting the dosage right to make a relationship stable so the patient can develop and mature psychologically.*

Psycho-dynamic therapy methods, music therapy being subsumised (Reimer & Rüger 2000), are most likely to encompass this goal. The definition of the therapist's role, propagated by E. van Deurzen supports this. She defines this role as “professionalisation of motherhood” (van Deurzen-Smith 1996, p 17). All definitions are based on the common objective of improving the patient’s quality of life.

The actual emotional stage of the patient will very often be the deciding factor of whether to strengthen self-confidence, offer special training, work dialogue-oriented or focus on dealing with the disease emotionally. As long as music therapy works functionally, it has similar objectives as physiotherapy or occupational therapy or even neuropsychology. It differs, however, from these fields through the medium of intervention. Sound makes it possible to enter into a relationship without necessarily being able to use or understand speech. Sound as a medium of intervention, speaks to other areas of the neuronal network because music and speech are not represented by identical areas of the brain (Spitzer 2002, p. 193).

Music therapy also offers a complementation to the classic treatment methods because sound is directed towards the emotional world of the patients. *The importance of emotions was underestimated for decades but gains more and more importance in the context of intensified brain research (Damasio 1999, 2004). It seems important for the future of music therapy to think not in terms of “either/or” concepts, but in “as well as”.* Only then will the patient’s need for a better quality of life be the focus of every treatment.

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CHAPTER 30

*Music therapy and learning
disabilities - a neuropsychological*

*perspective on music
therapy rehabilitation*

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This presentation consists of three main issues. I will start by talking about the concept of learning disability followed by some views on the treatment of learning disabilities. After that I will present the functionally oriented music therapy method as a neuropsychological perspective to music therapy and show you some video demonstrations of my clinical music therapy practice.

Learning Disabilities

Individuals, who display an educationally significant discrepancy between their estimated intellectual potential and their actual academic performance are usually classified as having some sort of learning disability. This discrepancy cannot be explained in terms of physical, sensory, intellectual problems or of emotional disturbance. The environmental, cultural or economic disadvantage are also excluded. This means that learning disabilities are disorders existing on the plane of psychological processing and not in general intellectual functioning. Current theories suggest that learning disabilities are the result of dysfunctions in the neurological processing caused by subtle disturbance in brain structures and functions.

As a term learning disabilities is a broad umbrella used for classification purposes to cover a wide variety of specific learning problems. These problems are manifested and identified in many different ways. A limited scope of learning disabilities includes for example specific difficulties in reading and writing (dyslexia), developmental speech and language disorders (dysfasia), mathematical disabilities (dyscalculia), developmental coordination disorder and disorders of attention. In the wider scope the learning disability may occur concomitantly with other handicapping conditions such as sensory impairments and mental retardation. In this presentation I have approached learning disabilities within the limited scope, which I just mentioned.

In everyday life learning disabilities have various kinds of outcomes depending on the classification of the learning disability. However, there are some general charac-

teristics or problems that may be found in many cases. One of the main areas seems to be difficulties in information processing including problems in visual and auditory perception, selective attention and a weak temporal and spatial orientation. There may appear difficulties in memory or conceptual thinking and concentration. Also difficulties in motor skills and verbal expression as well hyperactivity and impulsivity are common. In later school age learning disabilities might lead to behavioural and social-emotional problems as well as to the lack of self-esteem. Children with learning disabilities tend to have deficient social skills and are more often neglected or rejected by their peers. It has been shown that the social and educational development of children who have speech and language disorders may suffer significantly, even in those cases in which the problem appears to be relatively mild. This very heterogeneous group of symptoms demands special care and awareness both at from school and in rehabilitatory treatment.

Views of rehabilitation

In the terms of the rehabilitatory treatment of a learning disability one main direction of approach is that of neuropsychological rehabilitation. The basic tenet governing neuropsychological rehabilitation is the plasticity of the brain. This same phenomenon is also essential in the development of the brain and in learning ability. Plasticity refers to the ability of the nervous system to change in subtle ways. In normal brain training can induce relatively rapid changes in cortical organization. This reflects the plastic ability of the nervous system to acquire and retain new information and skills. In the case of rehabilitation when the main input to a cortical region is removed, the secondary inputs from nearby parts of the sensory map appear to become functional. This is called functional plasticity.

This ability of the nervous system is most active during early childhood and during developmentally important sensitive periods. Once these sensitive periods have passed (in late adolescence and in adulthood,) the central nervous system can be characterized by its marked decrease of plasticity. That is why the importance of rehabilitation in early childhood is so vital. The concept of plasticity is moreover the principal developmental concept in neuropsychologically oriented music therapy.

Learning disability may persist into adulthood although the character of the difficulty may change. For example early motor delay and difficulties in speech may reveal themselves in reading and writing problems when the child has reached school age. This change might be caused by two different mechanisms. Where of

developmental psychology the main point is that development occurs in a series of stages. These stages are hierarchically organized so that a later stage includes the characteristics of the earlier stages. Problems in earlier stages (i.e. sensomotor skills) may cause difficulties at higher levels (i.e. cognitive development). In this case rehabilitation should be based on work with earlier stages, which might have a positive effect at higher levels. The other mechanism emphasizes the functional separation of different areas. These areas seem not to have any developmental connections with each other. In this case rehabilitation is directed towards problems that are actual and perceptible for example motor skills.

Learning disabilities are usually divided into different diagnostic categories. In practice however the situation is usually different. It is normal that on top of the diagnosed main difficulty there often appear other manifestations of learning disabilities at the same time. This is called commorbidity. For example children with reading and writing difficulties can have attention problems and difficulties in mathematics. In the perspective of rehabilitation this means that the assessment of the entire developmental stage of the individual is needed. Based on this knowledge rehabilitation should take into account to both development of strengths and surmounting around the weaknesses associated with the individual learning disability. In the therapeutic situation one main goal is to offer individuals experiences on success that can lead to increased feeling of self-esteem. This is possible only by estimating the individuals' current functional age and levels and permitting then to succeed at their level. This functional age might be totally different to the biological age.

In neuropsychological rehabilitation selective attention and motivation are key concepts. These are the preconditions for successful treatment. Compared to neuropsychological treatment where a different kind of method is employed, music therapy has an enormous advantage because of the non-verbal, emotional and communicative nature of music. Meaningful interaction with music may also help an individual to focus his or her attention and to provide the necessary motivation in working situations. However, continuous repetition is required to internalize functional skills and characteristics. Therapy situation should also pay sufficient attention to working conditions and methods. Individuals with learning disabilities usually benefit from structured treatment programs as well as multisensory approaches and activities. In these terms we are aware of the possibilities that are contained in music.

Functionally Oriented Music Therapy Method

Functionally oriented music therapy method, referred to subsequently as FMT, is a neuro-muscular method of treatment. Originally this method came from Sweden where it has been developed since the late 70's. From the very beginning the collaboration with neurology, neurophysiology as well as physiotherapy and occupational therapy placed the theoretical base of the FMT within the neuropsychological frame of reference.

The theoretical background of FMT is based on the theories of the development of a human being and on the observations of his or her neurophysiological and neuropsychological development. The very first theoretical frame of reference was adopted from Piaget's theory of cognitive development. Piaget's basic assumption involves the idea of developmental stages, which are thought to form the basis of behaviour and to affect a child in a number of ways. Of primary importance here is the active role that children take in adapting to their environment. Theoretical basic ideas have also been adapted from the developmental theory of Gesell and from the sensory integration theory of Ayres. Gesell's theory of major motor milestones and principles of functional asymmetry, reciprocal interweaving and of developmental direction forms a firm basis for FMT. The same applies to Ayres's theories concerning sensomatory development.

As a method of rehabilitation FMT stresses its supportive character in the psychophysical development of the human being. Many individuals with learning disabilities have problems with body-awareness, perception and attention. These difficulties are often the main reason for the low self-esteem having an effect on the motivation and identity. That is why the psychophysical view of FMT is suitable for learning disabilities.

The main concept of FMT is associated with word functionality. In this connection functionality means first of all the individuals active role in the therapy situation where the whole functional capacity including motor function, perception, emotion and cognition is involved. This activity is based on musical interaction where the individuals' own reactions, experiences and insights of their own bodily function is the basis for motor learning. On the other hand functionality describes the main goal of the FMT treatment. The main objective of the treatment is to achieve the level of functionality where an individual in his or her own living environment is able to operate in a appropriate fashion.

The base for appropriate functionality is the individuals' awareness of his or her body and its' functions. This awareness develops through multisensory integration, our bodily movements and the feedback which we get from these movements. The feedback we receive, depending on whether we have managed or failed in our efforts concerning functional and motor activities is the base on which we mould our self-esteem and the concept of identity. Especially in our early childhood, when we are physically growing and attaining new functional skills day by day, the importance of the experience of our own body awareness has an enormous effect on our self-esteem and identity.

When considering individuals with learning disabilities, we become conscious of the many problems caused by defective body awareness. Very often emotional problems, low self-esteem or frustration tolerance are secondary causes of learning disabilities. The primary causes can be found in the weak body awareness, which often is a part of weak academic achievement. This justifies the attention to body awareness as a primary objective in music therapy treatment.

To reach this goal the FMT-therapist has to be very aware of all the developmental stages in human growth. The most important tool for the therapist is the ability to observe and understand non-verbal musical interaction and bodily functions as well as the changes in these functions. Observations made and changes noted in the therapy situation are evaluated on the basis of the theoretical knowledge of the developmental stages. The actual developmental age differs from to the biological age among the individuals with learning disabilities or other neurological symptoms.

In this functional process motor development and perception are closely linked to thinking and reasoning. Non-verbal interaction offers the client the possibility of organizing and coordinating their own thinking and planning from their own stage of development. It offers the possibility of discovering one's own motor control together with the experience of doing well. Aiming towards a more organized behaviour or enhanced body-awareness enables an individual to discover an ability to utilize their own body and functionality in order to realise their own thoughts and plans.

MAIN CRITERIA

When talking about observation as a main tool, what is it that is actually observed? I will now briefly describe the main categories of observation that are also the basis for assessment and clinical follow-up.

Like any other therapy orientation FMT-treatment is based on secure and meaningful interaction between the therapist and the client. Facing ones' own defective

functionality and working with it requires lots of courage, confidence and motivation. The space needed to surmount frustrations and upsetting feelings through non-verbal musical communication is founded on this secure interaction.

Stability is the main anchor in functionality. The word stability in this connection designates the clients overall psychosomatic imagine, holistic as well as differentiated function, body control and balance. Difficulties in stability may have a negative effect on all other areas of development.

Lateral difference / side difference, laterality, left of right handedness tell us about the ability of the right and left side to function independently. Side difference is directly connected to hemispheric specialisation and to the functionality of the corpus callosum.

Separated movements can be carried out, if side difference and dominance has become stabilized. By “separated movements” we mean the right and the left sides’ capacity to move differentially and to coordinate different movements simultaneously.

Cross movements are also related to the lateral difference capacity. When side difference is well developed, it is possible to cross the median line and to use the right hand on the left side of the body and on vice versa - the left hand on the right side. Cross movements are a precondition for the ability to read.

Body rotation / release of the trunk tells us about the holistic as well as the differentiated use of the trunk. This ability is seen in the fine control of the movements as well as in the control of muscular power.

Perceptive integration is monitored in auditory, spatial, visual, tactile and kinaesthetic perception during the therapy session.

Where the development of the hand is concerned, the following factors are observed: developmental stage ; the use of wrist, fore arm and upper arm and the ability to grasp.

Logical thinking and planning define the ability to understand and to advance one’s own activity in non-verbal interaction.

Other important areas to observe are concentration, attention and the total coordination of the body.

THE ROLE OF MUSIC

This method is non-verbal. The music used is the means of assisting the treatment. The music is the way to meaningful interaction and motivation but is also an audi-

tory stimulus that entices motor response. The energy in upbeats, intervals and triads is utilised to stimulate the client to react – to take the initiative and to be active.

The music used consists of specially composed short pieces called codes. The purpose of the codes is to connect a certain piece of music to a specific activity. They also help the client to analyse and identify the progress of the therapy session. The codes are modified to suit different levels of developmental stages. They include the functionality and earlier mentioned main criteria such as stability, lateral difference, etc. By playing the piano the therapist is mirroring different nuances of the communication and interaction as well as the functionality of the client. Drums, cymbals and wind instruments are the most important instruments used by the client. Through this musical interaction the functional level of the client is enhanced. This happens step by step according to the ability of the client.

With the way music is used FMT can be seen as a communicational and biomedical orientation of music therapy. The biomedical orientation establishes the human brain as the basic domain of treatment and the primary focus for change in music therapy. Clear links can be seen between FMT and the ideas of musical influences on cortical processing as well as the use of music for the recovery of physical and communication skills.

Based on the above mentioned the role of the music in FMT is to

- maintain meaningful interaction
- to assist auditory, kinesthetic and tactile perception by the appropriate use of musical stimuli
- to lead the unconscious physical reactions towards conscious movements
- to maintain attention and concentration
- to give space for individual thinking, planning and reasoning
- to increase initiative and motivation
- to build patterns of recognition and memory

Because of the neuropsychological nature of FMT, this method is a structured program of treatment. The structure can be found in the use of music as well as in the inner progress of the therapy. Repeating the same melodies and functions is a prerequisite for learning and for the internalization of the functionality.

FMT and learning difficulties

At present the definition of learning disabilities is mainly based on cognitive skills, language awareness as well as on problems in visual and auditory perception. In addition the FMT method calls attention to motor underdevelopment and to problems with co-ordination and perception. The actual music therapy has exposed difficulties in lateral difference, separate movements and cross movements. Often at school-age fine motor skills as well as eye-hand co-ordination are under developed. Difficulties have also been observed in the perception of one's own rhythm and in spatial perception. Every therapy process begins with an assessment stage consisting of three to five therapy sessions. Through the assessment the individual profile of development – the specific strengths and weaknesses – can be observed.

The FMT method is used as a tool for assessment and evaluation as well as a therapy form for clients who are functionally disabled or have certain neurological symptoms. FMT has been implemented successfully with patients suffering from learning disabilities including ADHD, CP and other birth related injuries together with the mentally retarded, Autism, and brain damage. The principles of FMT are also used in children psychiatry and the treatment of schizophrenia when the neuropsychological orientation and structured working method has been beneficial to the client.

Depending on the clients needs the focus and goal of the therapy varies a lot from supporting communication and interaction to the strengthening of bodily-awareness and functionality.

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CHAPTER 31

*Beethoven's "Tempest" -
Observations on the adherence
between music and psyche.*

Nierenstein, Simona & Katz, S.

In this paper, we would like to propose a parallel interpretation of musical language and intrapsychic activity, as described in the models defined by modern Infant Research.

With a clinical aim first and foremost, we would like to study the listening parameters of the therapy session in order to understand the meaning of the non-verbal dialogue and the music played and listened to within the music therapy relationship.

Beethoven's Sonata Op. 31 no. 2, an absolute musical masterpiece, is intended here as an observational workshop which will allow us to illustrate our basic hypotheses and arguments.

The basic premises of our hypothesis of musical analysis come from having identified a remarkable resemblance between the descriptions of the vitality states the child passes through in the earliest stages of development and the descriptions of musical language through its parameters.

These premises are:

1. From the very first days of life a child perceives stimuli in an amodal way, or rather, he has the innate ability to gather information with one sensory modality and to translate it into another.

Amodal perception implies the capacity to understand the unified nature of an object, beyond its specific sensory connotations. This capacity underlies the unification of the Emergent Self.

2. A child experiences his first abstract representations in the following ways:
as forms, or rather spatial patterns,
as rhythms and repetitions, or rather temporal patterns,
as intensity, or rather patterns of dynamic quantity and quality;
These are considered to be the most universal characteristics of experience: at their origin are physiological and sensory-motor processes and affective states.
3. In a dyadic interaction, form, rhythm and intensity combine into recognisable patterns which mainly allow for:
 - exchange of information on the state of the Self and of the Other
 - Self-regulation and regulation of the mutuality of the relationship;
4. Physiological, Sensory-motor, or Affective Patterns can be memorised from the very first months of life and we can return to them via non-verbal means.

In our opinion, this leads to further observations on the musical clinical side upon which our hypothesis is based:

1. The raw material from which music is formed is the same as that of our earliest means of relating to ourselves and to the world.
2. Music, composed, listened to and performed, has the power to recall and bring us back to amodal and pre-symbolic patterns that are etched in our experience;
3. Music is by nature polysemic, that is, it is the bearer of many meanings. At times the context may tell us which to choose, but often music leads us to accept this semantic ambivalence: the subject can choose not to exclude any of the meanings. "between contradictory emotions and images music is not obliged to choose" (Imberty 1985, pag 97)
4. At a clinical level music provides the opportunity to return to states **close** to the roots of the Self and which have not necessarily gone through a process of verbalisation;
5. A music therapist who is capable of carrying out a very detailed and specific analysis of the abovementioned parameters has the opportunity to understand the inner world of the client and to interact with him at a pre verbal ,yet sophisticated level.

In listening to the Tempest again together, we will see that the specific formal, harmonic, rhythmic, timbre and contour movement can correspond to interactive-emotional patterns recorded in the memory in a pre-symbolic way, first of all in the composer's, but then in the performer's and the listeners'.

Of each person according to his own individual contents. In our experience as musicians and listeners, the emotion and the physical reaction that we experience when faced with certain musical events can be considered as being connected to this level of perception.

To finish, we will draw some conclusions about the clinical significance of our hypothesis.

Listening to the exposition of the Tempest.

When we hear this music our innermost parts are moved, we feel that the flow of notes expresses something that is present and alive in each of us, we feel ourselves reflected in some deep inner part. We don't necessarily feel the need to give it a specific name, but "something happens".

This mysterious "something" is the subject of our discussion: we want to ask ourselves about its origin, its role and its meaning, although in a way that is free from the particular content it expresses. In other words, we are not focusing here on finding a relationship between the course of this sonata and the biographical events of Beethoven's life (even though it could be interesting).

We want to take a further step back and ask ourselves what these musical elements and movements correspond to, what it is in musical syntax that seems to imitate intrapsychic experience so closely.

We'll go back to the Sonata with three musical examples, observing in particular the role of tonality, contour and its division between the two hands, and finally timing and rhythm.

We work towards improving the quality of our personal and professional listening, in order to acquiring the sharpness and the profoundness that allows us to understand the semiological side of music, and then to go beyond this and get to the core of sound material that flows during a session.

This all remaining “without memory and desire” as W.Bion says(1962), in the “here and now” of the therapeutic encounter. Only in this way can we be fully attuned and allow an empathic comprehension and elaboration to happen, as in Kohut’s “vicarious introspection”.

Those reflections originate from a strong intuitive sensation that we had when reading the writings of Daniel Stern: the ‘vitality affect’, that’s what it is, that’s why this paused chord followed by the erratic run of quavers has such an unsettling effect! There in the distance is the Infant Self present in each of us that in this way has experienced himSelf, his soma Self, placed within its maternal constellation! An open, soft sound, held ad libitum, a calm state; and then a devastating and anxiety-inducing interruption, a sudden change of the heart’s rhythm, a contraction of an unforeseeable length!

Once again, reading D. Stern: form, tempo and intensity are the elements at the root of affective attunement, the behavior which allow sharing the feeling behind the act, a fundamental experience for the formation of the Subjective Self.

Here, in black and white, are the basic parameters of our chosen professional language! Our intuition, tested in clinical practice and in our personal relationship with music, has been progressively enriched by theoretical foundations taken from experimental observation.

Since the 1970s developmental research has aimed towards a description of a Systemic Model in which child and adult express themselves in a continuous exchange of sounds, rhythms and silences. They regulate each other through the length of visual and vocal exchanges and the interweaving of vocal and kinaesthetic contours.

This exchange is organised and gradually made coherent by the potentiality to attune according to corresponding properties. Through a process of continuous exchange, patterns are formed and stabilised, thus becoming predictable.

The recurrence of the patterns experienced in the encounter generates expectation and, from this, a sort of awareness emerges. Of course, a lack of, or too much recurrence also forms patterns which can evolve into more or less discernible pathologies.

The psychoanalyst Frank Lachmann in his conference ‘Words and Music’ highlighted the role of tonality as a container and moving away from tonal predictability as a renunciation of a universally shared fence.

Our Sonata opens with a statement: I am forced to leave the container, or I want to leave the container, or, better still, the container is inadequate, and this statement is made in a tone which is far from assertive, in fact it is almost gentle.

Let's look for a moment at the opening of the Sonata from the point of view of predictability, our Sonata is in D minor but it opens with a dominant chord of A Major: example

not yet knowing the tonal context of the Sonata we could expect a nice tranquil theme in A major (like for example...).

The sense of surprise created by the quavers which immediately follow, undeniably tending towards D minor, is all the greater.

Thus the soft, slow opening chord on the one hand promises stability, on the other generates instability and acts as a precursor to a change in state.

The after-effect is an intensification of the contrast: after the quavers movement the chord, played as an arpeggio, returns to the diminished seventh degree of the scale, a degree which is even further away from the tonic,

but in C major. A chord, therefore, with a strong cultural connotation of tonal home by it's essence, but which is actually a long way away from the specific home of the sonata: D minor.

Like insisting on offering containment, but on an essentially unstable base: as a result, the quaver pattern expresses the intensification of the vitality affect.

A feeling of arousal which is confirmed by the other musical parameters we will look at after.

Keeping to tonal observation, however, it is exactly this intensification which allows us to finally reach a dynamic shift which, in the 21st bar, brings us to a D minor chord on the tonic.

Continuing our discussion, we must now touch upon possibly the most basic assumption: the central role of musical elements in the mother child relationship is made essential by the proven amodal perception, that is by the possibility to cross information over from one sensory channel to another, shown in research to be an innate ability.

H. and M. Papousek(1996), for example, have observed striking transcultural similarities in the use of musical elements in the interaction modality which connect and integrate information in a multimodal way. There is an involvement and continuous exchange of information between the auditory channel and tactile, kinaesthetic, vestibular and visual forms.

To make it more concrete, we cite one of the classical example from Stern(1985;140) of an affect attunement based on the intramodality of perception:

“an eight and one half month boy reaches for a toy just beyond reach....he stretches toward it....still short of the toy, he tenses his body to squeeze out the extra inch he needs to reach it. At this moment, his mother says: “uuuuuh....uuuh!” with a crescendo of vocal effort, the expiration of air pushing again her tensed torso. The mother’s accelerating vocal respiratory effort matches the infant’s accelerating physical effort”

This is a simple demonstration of the ability to immediately, unconsciously and closely translate between the various sensory modalities, matching the affect of each other member of the dyadic system.

This means that the representation is not necessarily linked to the modality in which it is expressed, it is therefore an abstract representation to some extent even if it is not symbolic. For example, we can imagine that the pleasant sensation, expected and interiorised, associated with the contour, the intensity, the length of a caress can be connected to the pleasant sensation associated with the features of mother’s calm voice, forming a pre-symbolic and amodal pattern with a clear sound connotation. And thus also the pattern which a sudden, loud, staccato sound establishes with a brusque movement.

Beatrice Beebe and Franz Lachmann say: “The ability to abstract what perceptively differentiable entities share, and to generalise on the basis of these abstractions makes a rudimentary form of representation possible, which allows the development of language and symbolic thought.”(1992,70 in *It. Trans*)

Let’s go back to our Sonata for a moment and examine it with regard to the contour as outlined in the collaboration between the two hands:musocal examples.

The opening chord is harmonically split between right and left, it goes from low to high-pitched and it covers a wide range.

We can imagine a fragment of a pattern, appropriately recorded.

Let's look at the symmetrical contrast provided by the second fragment. The movement is in contrary motion,

the contour is broken and returned, the register is narrow and it opens, concertina-like, while moving closer and closer towards the high register: Piano

we can observe the left hand which gradually abandons the accent on the downbeat, adapting itself to the instability of a marked offbeat rhythm. PIANO

Then, in an almost headlong fall, we arrive at a hammering unison accented on the upbeat. Once again, a message of strength and instability at the same time.

But even more interesting is the fact that, in finally leading into the D minor theme, the two hand swap roles: the left takes the theme, which only seems new but actually joins the previous two fragments (the arpeggio and the seconds),roaming and expanding it freely from one end of the keyboard to the other.

while the right, in the centre, trembles.

We don't know how many possible intrapsychic and interpsychic inferences are crossing your minds in this moment, we have many, and we would like to share them with you later.

Maybe images of internal dilemmas can arise, maybe interpersonal interactions, maybe physical experiences. What we believe is clear is that, with a temporal consciousness which would be unthinkable through verbal expression, and with an adherence to the sensory detail which permeates experience, an extremely meaningful emotional sequence is expressed here: note that we aren't talking about "dramatic", "exciting", "racking" or "sorrowful", but simply meaningful.

Some of you might be asking yourselves what we are telling you here, if we're not talking about specific meaning.

We're saying that the raw material that forms the parameters that are then organised into musical language is the same as the raw material of our first modality of relating to ourselves and to the world, and that this raw material remains forever, even in adulthood, contiguous to the core of experience.

But now we must ask ourselves, how do we preserve the memory of that raw material? Experimental observation shows that these patterns can be memorised: in fact, memories are permanent, even if they are not always retrievable, and it has been

proved in neurophysiological terms that the greater the intensity of the affect which accompanies the memory, the greater the depth with which the memory is recorded. A sort of pre-symbolic emotional memory which can be recalled, in non-verbal terms, even before a semantic system based on symbols or language emerges.

The ideas of the psychoanalyst Wilma Bucci(1997) are also consistent with our hypothesis. In her recent theory of multiple code, she argues the existence of two parallel systems of representation, verbal and non-verbal, and that both involve symbolic elaboration. In the non-verbal system perceptive informations are organised into structures and become symbolic even if not translated. An adult's memory is based on these early non-verbal structures, which can be translated with the help of psychoanalysis.

Our hypothesis therefore implies that music allows us to relive these early memories, and therefore that psychodynamic music therapy is an extremely powerful mean for bringing them back to life within the setting.

As the last observation parameter for our sonata we chose timing and rhythm, unanimously thought to be central to the process of organising relationships and therefore pre-symbolic representations.

A characteristic feature of Beethoven's writing in this period, and of this piece in particular, is the rhythmic fluctuation, a feature whose importance in terms of stylistic innovation in relation to the classical sonata is also worth highlighting.

Maybe could be enough to note that in the first eight bars we see five indication changes: Largo, Allegro, Adagio, Largo, Allegro, a refusal to conform to a uniform and unifying pulse. In the slow parts a kind of fluctuating pattern emerges where the tempo seems to spread in relation to the strong expressive needs: this is particularly evident at the end of the development, the moment when a surprising recitative begins to which Beethoven gives the indication "con espressione e semplice" (with expression and simple). Musical examples:

The expressive force is heightened by the long pedal point, original, which fuses and confuses the sounds, creating the effect of a dissonant sound fog and the emergence of the harmonics, a tendency to "fade away."

This pattern strongly contrasts with, and is in turn interrupted by, the speed, clarity and impetuousness of the well-known rhythmic pattern in quavers.

The growth in intensity created by the repetition of this contrast causes it to lead into something else, which, upon closer inspection, is the dense and rhythmic transformation of the chord and the arpeggio.

This time it is not left free and slow, but is actually meticulously transcribed into a rhythmic, subdivided and quick form.

Listen to the subdivision in *ralenty* ...and in *tempo*

To paraphrase F. Lachmann, we could say that the free and dissonant expressiveness is violently contained, or even caged, by its rhythmic transformation which, by completely distorting its character, turns it into something else.

The contrast between rhythmically opposite patterns, which we also find in the other two movements of the sonata, confirms and completes both what has already been said by the harmonic contrast and what we have highlighted regarding the contrast in the collaboration between the two hands.

In their studies B. Beebe and F. Lachmann(1992) give large space to observations on rhythm which, being present in every type of relationship, gives us continuous feedback as to the other person's state and therefore also our own. J. Jaffe's (1992) research on vocal interaction provides data which we are keen to highlight: the ability to perceive time at a level of fractions of a second exists from birth, and temporal responsiveness is seen as fundamental in the micro-organisation of "being with".

It is an innate perceptive ability which gives us an essential form of control in a relational context.

Some studies have proved an important piece of information: the level of coordination of vocal timing reached at 4 months of age between the infant and the adult who takes care of him allows us to predict the quality of the attachment that will have been reached by 12 months of age (a high level of coordination leads to an anxious-resistant attachment, a low level to an avoiding attachment, while the optimal is somewhere in the middle).

Coordination of the timing of rhythmic interaction is fundamental for affective regulation, and is therefore essential for letting others, and thus ourselves, know our interior state. It seems clear to us that traces of the rhythmic temporal coordination, or lack of it, experienced in early childhood remain impressed in the experience of

the Self and are then returned to and expressed again in many ways, behaviors and modalities.

It seems to us self evident that they are reflected in an accurate way in the rhythmic structure of music and they can be revived through composing, executing, improvising and listening.

We also believe that when listening to music we resonate with memorised rhythmic patterns, which have a different specific meaning for each of us, but often also a component that can fundamentally be shared.

In conclusion, we would like to concentrate for a moment on the clinical implications of this journey, which deserve a much longer chapter, that we don't have the opportunity to elaborate with you, at the present.

To quote T. Ogden(1997,8 In It trans): "Words, when they are alive and breathing, are like musical chords: the full resonance of the chord or melody must offer itself up to listening in all of its evocative imprecision. In our use of language... we must try to compose music, rather than produce notes"

It is interesting that Ogden, a psychoanalyst and not a music therapist, highlights the importance of being able, within the therapeutic setting, to match through words the evocative power of music, in its precious imprecision.

How lucky we are, in having the possibility to use, not only words as music, but music itself!

In fact, our specific profession enables us to listen to and master musical parameters so as to allow deep resonance and attunement with the entire non-verbal dialogue that unfolds as a continuous process within the setting, when we play, when we listen, when we talk or are silent and breath with our client. Then, with a further step, we can improvise with our client, going with him through the movements of his inner world with the help of the indefinite preciseness of musical syntax. Yet, without going through the "double edged sword" (Stern, 1985; 162) of verbal categorization.

Following the train of thought developed in a musical sense by Knoblauch in "The musical Edge of therapeutic experience", (2000) through musical exchanges we can contact the client and, with him, go back over the fundamental patterns that are etched in his experience.

Embedded in the pathological part of the self we can find patterns which are still a long way from being able to go through the process of verbal symbolisation; excessively rigid at times, at others not enough predictable.

Repetitions, variations and changes in form, rhythm and intensity, heard in the fascinating complexity brought about by means of cross-modal understanding, offer us an extraordinary language for comprehension, interaction and elaboration

Just like Beethoven's "Tempest", in light of the connections it has stirred in us with the pre-symbolic world, may now have also roused in us new lights and shadows, winds and contrasts of clouds.

The therapy session as an improvised duet, therefore, in which no musical development is blocked by "knowing prematurely" or by an early assignation of categorical meanings which can only flatten the meaning of the music.

Unfortunately, or maybe fortunately, far from wanting to violate the mystery of music, we wanted to share these observations with you, in order to be able to forget them better, later... on.

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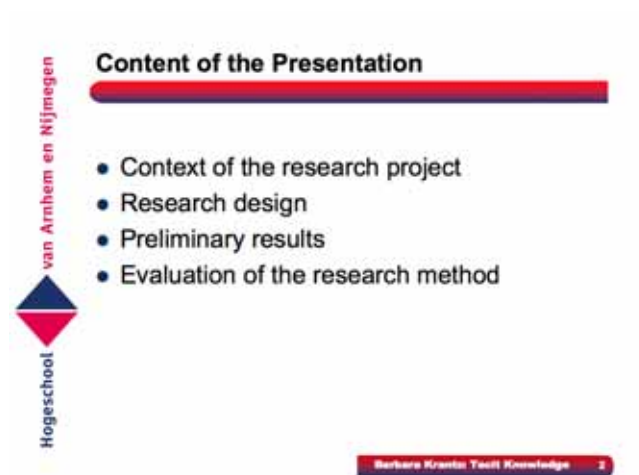
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CHAPTER 32

*Expliciting the tacit knowledge of arts
therapists - a research project in
Holland*

Krantz, Barbara

**This presentation has been send as a
Powerpoint file**



Context of the Research Project

- Situation in Holland
- Research group

Barbara Kranitz Teelt Knowledge 3

Situation in Holland

- Arts Therapy: Art Therapy, Dance (Movement) Therapy, Drama Therapy, Music Therapy
 - Psychomotoric Therapy
- ⇒ Training: different bachelor institutes
- ⇒ Practice: same kind of work
- Fusion: "Specialised Therapies"

Barbara Kranitz Teelt Knowledge 4




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Research Group

- Background: University of Professional Education
- Training programmes: Arts Therapy, Cultural Social Work, Social Educational Care, Social Work and Social Services, Continuing Professional Education
- Supervisor: New Professor Dr. Kitty Kwakman
- Researchers: one teacher from every training programme
- Aim: professionalisation of social workers and specialised therapists

Barbara Kranke Tacit Knowledge 8



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Professionalisation

- Lots of experienced professionals
- Few publications
- No explicit body of knowledge

⇒ Explicit the tacit knowledge

⇒ Produce new knowledge about the profession

⇒ Research what experienced professionals actually do

Barbara Kranke Tacit Knowledge 8

Research Design

- Title: Interventions of Specialised Therapists
- Type: clinical study, inventory, descriptive
- Methodology: qualitative
- Method: Stimulated Recall Interview
- Participants: 4 specialised therapists (1 art, 1 drama, 1 music, 1 psychomotoric therapist) working at a psychiatric hospital

Barbara Kranitz Teelt Knowledge 7

Research Questions

- What (kind of) interventions specialised therapists use during an activity?
- What is the effect of the research method?

Barbara Kranitz Teelt Knowledge 8

Definition

- Intervention: action + intention (not necessarily conscious)
- Activity: an unity within a therapy session of a certain duration which focuses on one or more aims (also called game or exercise)

Barbara Kranitz Tacit Knowledge 8

Stimulated Recall Interview

- Therapist describes an activity in a form (co-operation with another project)
- Therapist is videotaped when performing the activity in a clinical situation with one or more clients
- Therapist watches videotape together with researcher, describes interventions and the thoughts and feelings she/he can recall

Barbara Kranitz Tacit Knowledge 10

Preliminary Results

Preliminary results are based upon:

- 4 Stimulated Recall Interviews (with 1 art, 1 drama, 1 music, 1 psychomotoric therapist)
- Transcriptions of the 4 interviews
- First analysis of 1 interview (with the psychomotoric therapist)
- Analysis of 1 evaluation of the research method (with the music therapist)

Barbara Kranitz Teelt Knowledge 11

First impression: correspondence

- Time, tempo and emotions are important aspects
- Activities or interventions are based upon (information from) earlier sessions or activities
- All therapists refer to the case history of their clients
- The right amount of support or challenge for the client(s) seems to be important

Barbara Kranitz Teelt Knowledge 12

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First analysis

- "Intervention": has a direct link with the research questions
- "Reflection": probably the most important moments of the interview for the therapist (for example: what the therapist realises during the interview)
- "Others": interesting statements but without a direct link with the research questions. Mostly complementary information (for example: influence of the camera)

Interventie van vaktherapeuten 13

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Interventions

- Verbal interventions
- Art interventions (art, drama, music, movement interventions)
- Predictable moments
- Unpredictable moments

Interventie van vaktherapeuten 14

Predictable Moments

- Instruction
- Choosing the material
- Offering the material
- Start of the art activity
- During the activity
- Feedback
- End of the art activity
- Evaluation of the activity

Barbara Kranitz Teelt Knowledge 13

Unpredictable Moments

- The group does something (1)
- One client does something (17)
- The therapist gets an idea (2)

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What does the client do?

- Does not join in
- Does not keep to the rules of the activity
- Goes on (too) long
- Seems unable to invent a movement
- Has pain; laughs; sighs; has pleasure
- Is overstrained
- Experiences all movements as painful
- Talks about the home situation (whereas it doesn't fit the activity)

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What does the Therapist do?

- Talks in the SR-interview mostly about the difficult moments and moments of doubt, her considerations and her struggle with the role of therapist
- Uses diverse interventions
- Reacts in a different manner on equal situations

→ No pattern found till now

Barbara Kranitz Tacit Knowledge 18

Evaluation of the Research Method

- Benefits for the participant
- What gets clearer to the participant
- Reflections of the participant
- Beliefs of the participant
- Observations of the interviewer

Interventie van vaktherapeuten 19

Benefits

- *I get things clearer.*
- *Because of all those questions I see what I wouldn't remark by myself, or what I take for granted.*
- *Something I don't remark by myself happens to have a function.*
- *All in a sudden I see how what the client does has an influence on me.*
- *When I watch the tape I am able to recall what I thought then, indeed.*

Interventie van vaktherapeuten 20

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What gets clearer

- *How I literally stand away in body language.*
- *The repeating melody I play happens to have a function.*
- *I am working hard, I am really busy.*
- *I am working very intense, you can get really tired from that.*
- *I'm trying to get in tune with the client.*
- *The function of the music: offers support and structure, fills up silence, builds up tension and breaks it down.*

Interventie van vaktherapeuten 21

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Reflections

- *I'm trying to get in tune but all the time I keep having doubts: do I support the client by doing this, is there a benefit for the client, is this the right manner to get where I want to get?*
- *On the one hand I keep following the client, but on the other hand I have to keep it under control without frustrating him [the client].*

Interventie van vaktherapeuten 22

Beliefs

- *For traumatised clients it's very important to experience having things under control.*
- *They [the clients] are afraid of losing control.*
- *On a certain moment they can give up control too much.*
- *On such a moment I think I have to be able to take over control.*

⇒ Interventions are based upon these beliefs

Interventie van vaktherapeuten 23

Observations of the interviewer

- The therapist is permanently reflecting about how to act: follow the client or lead, get in tune or try to be (more) directive, keep control or give up control.
- "Having control" is an item that is connected to the disorder of these clients.
- The therapist keeps trying to get musically in tune with the client.
- Assumption: a good or suitable activity might be a precondition but is surely no guarantee for reaching the aims of a therapy session.

Interventie van vaktherapeuten 24

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Effect of the SR-Interview

→ Stimulated Recall Interview seems to be an effective method for helping professionals to explicit their tacit knowledge.

Interventie van vaktherapeuten 25

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Possible uses of the SR-Interview

- Research: tool to describe practice, reflections and beliefs of the therapist
- Clinical situations: method to promote professionalisation
- Training programmes: method to promote reflection on practice
- Supervision: method to promote reflection on beliefs

Interventie van vaktherapeuten 26

Thank you for listening!

CHAPTER 33

The psychological goals for engaging in music in adolescence

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Abstract

The paper discusses the psychological reasons for the importance of music in the everyday life of adolescents. A theoretical categorization of psychological goals and motivations is proposed. The categorization is created in a dialogue between previous studies about music consumption and the meanings of music and theories of adolescent psychosocial development. The categorization is a theoretical framework for understanding how music may work as a health promoting factor in adolescent life.

Aims: understanding the importance of music for adolescents

Music is an integral part of adolescence. It is constantly present in the lives of adolescents, and young people often feel seriously devoted and passionate about the music they consume (North, Hargreaves & O'Neill, 2000). Christenson and Roberts (1998) argue that maybe the clearest marker of adolescence is a passion for popular music. If we want to understand adolescence these days, music is essentially involved. Why then, is music so important for young people? The aim of this paper is to discuss the meaning and importance of music in the everyday life of adolescents.

The meanings of music to adolescents are viewed from a psychological perspective. The reasons for musical behavior are considered to be internal and engagement in music is seen as a goal-oriented activity of the psyche. Several researchers have stated that music is being employed for psychological and even therapeutic outcomes in everyday life (Ahonen-Eerikainen, 1996; DeNora, 2001; Laiho, 2002; Lehtonen, 1984; 1985; Ruud, 1997b). Sloboda and O'Neill (2001) argue that therapeutic effects of music do exist in everyday life, but the mechanisms by which they are mediated are poorly theorized. The purpose of this paper is to discuss these psychological and therapeutic outcomes of musical activities in the lives of adolescents and to increase theoretical understanding of those psychological goals and motives that make music so important for adolescents. The paper also aims to discuss how the psychological goals of music consumption are related to well-being and health.

Method: creating a theory-based synthesis

This paper presents a theoretical categorization about the psychological goals for engaging in music in adolescence. The categorization was created to increase theoretical understanding of the role of music as a meaningful part of adolescent life, development, and psychological well-being.

The categorization is based on previous literature from several disciplines. A variety of both theoretical and empirical studies was reviewed. The focus was on studies concerning adolescents and the meaning of music in everyday life. There has

been done several empirical studies about the reasons for music consumption and these studies have been reviewed by, among others, North, Hargreaves and O'Neill (2000), Wells and Hakanen (1991), and Zillmann and Gan (1997). One approach comparable to the perspective of this paper is the uses and gratifications approach used in media research. It studies music consumption from the perspective of the consumer. Instead of studying the effects of music on the listener, it concentrates on the goals and motives of the consumer. Music is seen as a purposeful activity of the individual and individuals are considered as active agents who engage in music to satisfy their personal needs (Arnett, 1995; 1995b; De Nora, 2001).

Research done under the uses and gratifications approach and in several other fields considering the meanings of music is seldom focusing solely on the psychological meanings. However, certain psychological goals are recurrently found also in studies that are broad compilations of all possible reasons for engaging in music. The categorization was created through a kind of qualitative analysis on the literature. Different themes that could be related to psychological functioning were searched from the literature. These themes were then grouped under more general themes and categories. In a sense, the categorization was a synthesis of previous research literature. In table one there are examples of some psychological themes which were found in previous studies and then grouped under the main category of "interpersonal relationships". Under each main category there were around fifty themes.

| |
|---|
| TABLE 1. An example: Themes under a category of "interpersonal relationships" |
| INTERPERSONAL RELATIONSHIPS |
| Youth culture identification (Arnett, 1995) |
| Social utility, withdrawal (Christenson & Roberts, 1998) |
| Interpersonal relationships (Hargreaves & North, 1999) |
| Unity and isolation (Laiho, 2002) |
| Renegotiating relationship with parents (Larson, 1995) |
| Background for courting, autonomy, importance of peers, discussion topic (Larson, Kubey & Colletti, 1989) |
| Develop relationships (Lull, 1987) |
| Social motive (Persson, 2001) |
| Belonging (Ruud, 1997b) |

In addition to creating a synthesis of previous literature a theoretical understanding was introduced. Very few studies about the reasons for consuming music are linked with psychological theories. However, theoretical understanding of these reasons is a starting point for creating a comprehensive conception of music as a psychologi-

cally meaningful factor in adolescent life. Therefore, the categorization was formulated in a dialogue between previous empirical studies and psychological theories. Several theory-based studies from the fields of music therapy and music psychology were influential, but the most important theoretical grounding was based on the developmental psychology of adolescence. The meaning and importance of music to young people seems to be tied to their psychosocial development (Laiho, 2002; Larson, 1995) and for example, Arnett (1995) has stated, that there is an urgent need for conversation and collaboration between the scholars studying the uses of media for adolescents and the scholars in adolescent development. Therefore, the developmental tasks of adolescence were considered when formulating the categories. The research process started with analyzing the findings of the previous empirical studies and the formulating themes and categories based on them. Theoretical understanding was introduced to provide these created categories with theoretical conceptualizations and explanations.

THE CATEGORIZATION: FOUR FIELDS

The categorization consists of four different fields of psychological goals. These goals are: identity, agency, interpersonal relationships, and emotional field. They represent different psychological goals that motivate and give meaning to musical behavior in adolescence. Next we shall consider each category in detail.

1. Identity

One of the major tasks in adolescence is the reconstruction of the conception of self and establishment of adult identity. Adolescents have to face significant changes in different issues related to self such as body image, sexuality, and close relationships. They puzzle over moral issues, future occupation, or values and ideologies. Because of this identity work adolescence is a time for increased self-reflection. (Aaltonen, Ojanen, Vihunen & Vilén, 1999; Durkin, 1995; Erikson, 1968; Jarasto & Sinervo, 1999; Larson, 1995).

Music may help this self-reflective activity. Several researchers have argued that music may work as a reflection of self and issues related to self (Christenson & Roberts, 1998; DeNora, 2001; Ruud, 1997a; Small, 1998). According to Lehtonen (1986; 1991; 1993; 1995) music serves as a meta-structure into which individuals can place personal meanings. Music is an emotional framework for the interpretative activity of composing constructs related to self. Another important character in music is that it discusses adolescent concerns. Popular music songs include themes like sexuality, autonomy, individuality, romantic love, family values, social change, drugs, and religion (Christenson et al., 1985; Wells and Hakanen, 1991). Music is an enjoyable and a distant enough way of contemplating these issues and it may

also give structure to self-reflective thoughts. That way it promotes self-exploration and self-knowledge.

Music may be a way of getting to know oneself better, and due to its symbolic quality it may also help strengthening and expressing the existing conception of self. Musical preferences can reflect distinct personal values that are different from the values of others, favorite or familiar songs may give feelings of continuity and coherence in life and musical expression may be a way of performing the sense of self to self and others. (DeNora, 1999; Hargreaves & North, 2000; Laiho, 2002; Ruud, 1997a; 1997b.)

2. Agency

The concept of agency is used here to describe experiences of control, competency, and self-esteem. It could be defined as a feeling of being the commanding, competent, and successful actor of one's own functioning. Adolescence is a time for great changes and challenges. Adolescents need to take control over their own life and find balance between their personal and environmental demands and resources. The feeling of agency is an essential part of their well-being. (Csikszentmihalyi and Larson, 1984, p. 234-237; Shaffer, 1996, p. 464; Ruud, 1997b; Vuorinen, 1990, p. 141-150.)

Music can be an effective means for getting experiences of control and mastery. Music is a way of controlling environment through self-chosen songs in self-chosen times, places and volume levels (DeNora, 1999; Järviluoma, 1996). Music is one of the activities which are usually under the control of teenagers themselves, and adolescents appreciate hobbies which are uncompelled, self-chosen and informal (Laiho, 2002). Music can also be a way of controlling emotions and inner impulses (Ahonen, 1993, p. 266-267). Music may give experiences of learning and achieving and be a means to succeed in something that is felt important and meaningful (Kosonen, 2001, p. 84; Laiho, 2002). These experiences of control, capability, mastery, achievement, and success can strengthen the fragile self-esteem of adolescents.

3. Interpersonal relationships

The category of interpersonal relationships includes two conflicting needs: the need for belonging and the need for independence and privacy. These issues become essential in adolescence when one of the challenges is to readjust important object relationships. Adolescents need to separate from their parents and at the same time their social environment broadens as they form new social contacts, peer groups, and sexual relationships. Adolescents have to adapt to these changes and learn to

balance the conflicting needs for closeness and isolation. (Aaltonen et al., 1999; Erikson, 1968; Ruud, 1997a; Vuorinen, 1998.)

Music may help to balance these needs, because it is able to symbolize both connections and boundaries between us and others (Laiho, 2002; Lehtonen, 1985; Ruud, 1997a). Music can promote the separation process from parents and childhood family. It has often been stated that popular music is a way of rebelling against authorities like school and parents. However, it seems that more than being a vehicle of rebellion, music is for adolescents a way of renegotiating their relationship with parents and seeking independence and privacy through personal musical preferences and activities (Christenson & Roberts, 1998; Järviluoma, 1996; Laiho, 2002; Larson, 1995). Larson (1995) states, that through music adolescents can make symbolic personal space and declare: I exist, I am me with my own tastes.

Music is also a strong unifying power. It provides collective emotional experiences in countless social situations, and enhances social communication and peer group identification for example by communicating values and creating atmosphere (DeNora, 2001; Christenson & Roberts, 1998; Hargreaves & North, 1999; Laiho, 2002; Larson, 1995; Larson et al., 1989; Lewis, 1987; Lull, 1987; Ruud, 1997b). Music can enhance creating connections with peers but also with parents and other adults. Music is also able to create a feeling of belonging even if no one else is around. It reduces loneliness and reminds us about close people, or may itself be considered as an understanding and valued friend (Laiho, 2002, p. 71; Lehtonen, 1995; Sloboda, 1992; Small, 1998, p. 202; Åkerblad, 2001).

4. Emotional field

For many people the most important reason for creating and consuming music is probably the capability of music to evoke emotional experiences. The centrality of emotion in musical experiences is shown in a great number of empirical studies (Christenson and Roberts, 1998, p. 47-49; DeNora, 1999; Laiho, 2002; Roe, 1985; Sloboda and O'Neill, 2001; Wells and Hakanen, 1991).

The emotional qualities of music may be especially important for adolescents, because their everyday experience is often emotionally intense and restless, and they need means for emotion regulation. Music suits well for the task of emotion regulation because it has the ability to affect subjective cognitive, bodily, and self-conceptual stages, create a wanted atmosphere, and put a person in a right mood for almost any activity or situation (DeNora, 2001; Laiho, 2002; Lull, 1987).

Music may help adolescents to cope with negative emotions. As a symbolic object it enhances self-reflective mental work of identifying feelings, clarifying thoughts, and working through conflicts (Behne, 1997; DeNora, 1999; Laiho, 2002; Larson, 1995; Lehtonen, 1984; 1985; 1993; Ruud, 1997b; Sloboda, 1992; 2001; Small, 1998, p. 160-171) and enables safe and acceptable expression of difficult, violent or disapproved thoughts, feelings, and impulses (Ahonen, 1993, p. 139; DeNora, 1999; Erkkilä, 1998; Laiho, 2002; Small, 1998). Music may also be used as a distraction from current situation and worries and as counterbalance for schoolwork and daily routines (Behne, 1997; Hargreaves & North, 1999; Laiho, 2002; Larson et al., 1989; Lull, 1987; Sloboda, 1992).

However, music is not only a means for coping. People frequently engage in musical activities simply for pleasure, enjoyment, and new experiences. The importance of positive feelings and enjoyment may be essential for health, because these revitalizing experiences provide individuals with a sense of well-being and coherence, and make them feel good about themselves. (Laiho, 2002; Larson, 1995; Lull, 1987; Ruud, 1997b.)

Conclusions

The categorization consists of four different fields: identity, agency, interpersonal relationships, and emotional field. The categories and their main points are gathered under table 2.

TABLE 2. The categories and their main points

IDENTITY

- Self-exploration and getting to know oneself better
- Feeling of being unique and distinct from others
- Experiencing coherence and continuity in self
- Self-expression

AGENCY

- Feelings of control
- Experiences of learning, achieving, and being competent and successful
- Self-esteem

INTERPERSONAL RELATIONSHIPS

- Privacy, independence, and separation
- Belonging

EMOTIONAL FIELD

Working through negative feelings

Distraction from stress and worries

Enjoyment, pleasure, and new experiences

The categories represent the main psychological goals or inner motivational factors for engaging in music in adolescence. These goals give meaning to musical activities and make them important for adolescents. The categories are not meant to encompass all possible reasons. The main points gathered under each category are only suggestive, and future research could define the categories in more detail. The purpose of the categorization is to serve as a broad framework which helps to situate and understand these specific reasons and motivations in the wholeness of adolescent life and development.

More research is also needed about the relationships between categories. In my future work, I shall concentrate more closely to the emotional field and its connections to the other three categories. The motivational and emotional factors of individuals are complex phenomena, and every attempt to theorize or categorize them has to compromise between theoretical clarity and wholeness of subjective experiences. The categorization does by no means argue that all categories are equally important or even present in different contexts, at different times, and for different individuals. The purpose is to clarify theoretical understanding of the possible underlying psychological goals.

The categories are strongly related to the developmental tasks of adolescence. The categorization combines findings from different empirical studies with a theoretical

understanding. It serves as a framework for studying the role and importance of music in adolescence. The importance of music to adolescents can be understood in relation to adolescent life, development and well-being. The categorization also describes how music may promote well-being in the context of everyday life: it enhances adolescent development and the satisfaction of psychological goals.

The discipline of music therapy may also benefit from understanding the role of music in the everyday life of adolescents. Community music therapy has broadened the scope of music therapy closer to everyday life contexts. Dialogue and collaboration between different disciplines interested in well-being, music, and adolescents, is important for building theoretical understanding of music as a health promoting factor.

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CHAPTER 34

*AIVOBLUES - stroke
rehabilitation with music
therapy*

Laitinen, Mikko

Poster Presentation

The usefulness of music therapy for stroke survivors is discussed. Band-playing with figurenotes was used as a music therapeutic intervention. During three years

time data was collected of the functions of the hands with sensorimotor evaluation tests and of the perceived health status with RAND 36-item health related quality of life survey (SF-36).

METHOD

The participants came free-willingly to this pilot study after an announcement in the Stroke-newspaper. Six stroke survivors formed the group. The members of the group had different kinds of stroke: half of them had had an infarct and the other half hemorrhagia. Two of them had severe physical problems - hemiparesis - , two suffered from afasia and two had memory/thinking difficulties. Group members were 37–82-years old, mean 60 years, and time from attack varied from 1 to 20 years, mean 10 years. Half of the participants were males.

Group music therapy lasted for three years and had 31 sessions during the years 2000–2002. Two therapists, a physiotherapist and a music therapist, were leading the group and assisting the players. The stroke patients played the instruments they desired: there were many djembe-drums, a drum set and rhythm percussions as well as melodic instruments such as an electric bass, keyboards, an accordion and xylophones. Every session began with percussion training to get the common beat followed by playing with the chosen melodic instruments. During every three periods the Aivo-blues-group also performed playing common Finnish pop- and folk-songs.

The evaluation of the hand-function was done before and after each treatment period which consisted of seven 1,5 hours session. The RAND 36 -survey was carried out four times: in 2001 and 2002 before and after the therapy period.

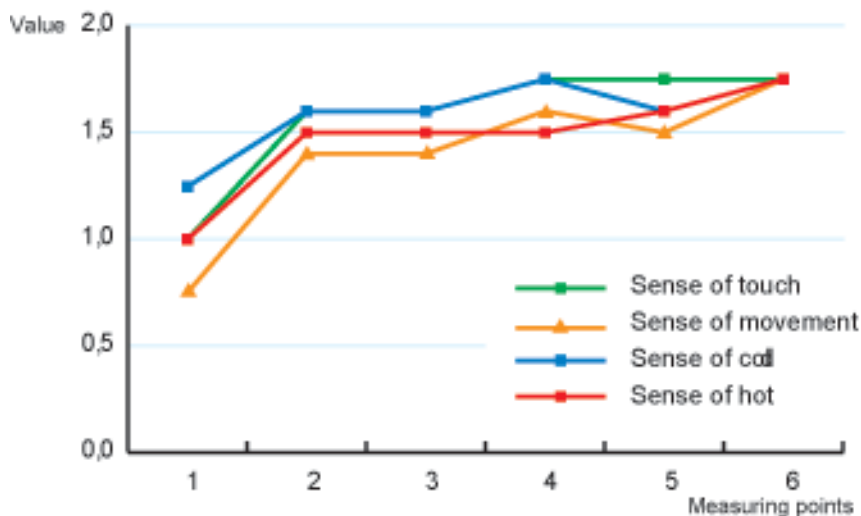
RESULTS

The RAND 36 -survey indicated that the participant's perceived physical and emotional role functioning, mental health and lack of bodily pain were improved two times compared to the starting point; physical role functioning even 2,7 times better.

The sensorimotor tests showed sustained effect of the senses improvement compared to the starting point. This is shown in figure 1, where value 2 indicates nor-

mal sense. Box & Block -test which evaluates the gross motor skill of grabbing and releasing and crossing the midline showed 10 % improvement during the therapy period. This may indicate that playing does improve the grabbing and releasing functions. Crossing the midline while playing was crucial with the patient with neglect: she was able to turn her head and hand to the affected side which is an important aim in rehabilitating those patients.

FIGURE 1.



CONCLUSIONS

The results support the active playing for improving sensorimotor skills and perceived health condition with stroke patients. This study suggests that group music therapy may be an effective rehabilitation method for those patients. Participation is in interaction with activities and body functions and it deals with health condition as is visualised in WHO:s ICF model (figure 2). An intervention in one component can potentially modify one or more of the other components. In my experience, participating in a music activity has a positive effect on health. Music therapy is useful and multidimensional rehabilitation method with stroke survivors and it may improve their quality of life.

FIGURE 2.

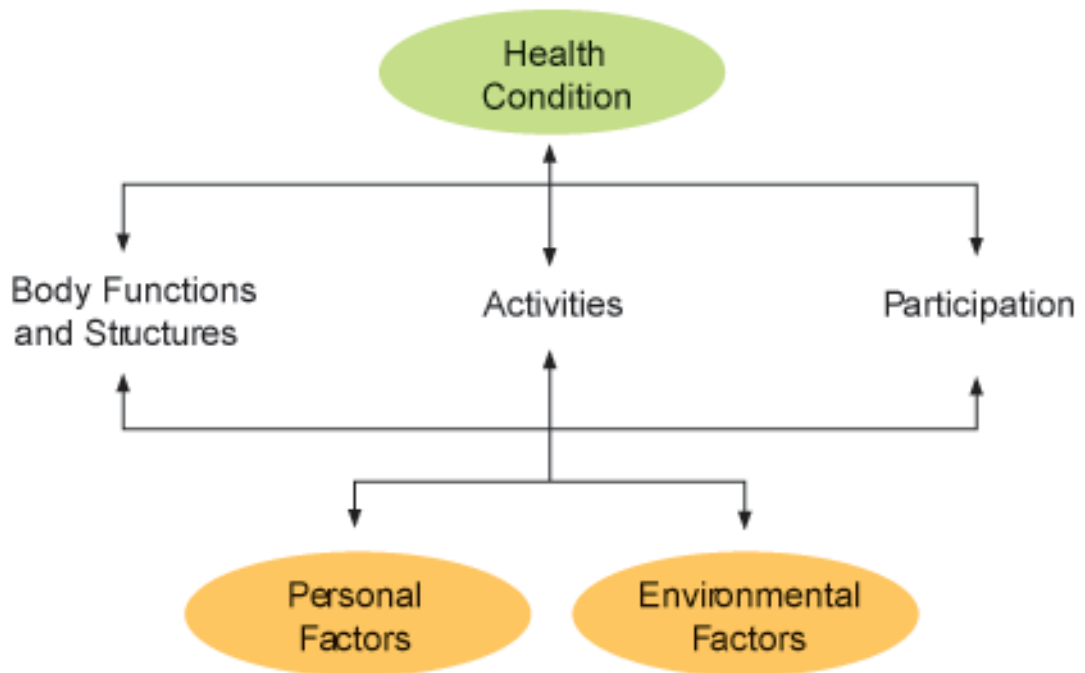


Figure 2.

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CHAPTER 35

*Music therapy for three hundred
three years old children*

**Mosca, Luciana; Di Franco, Gianluigi &
Moselli, Bianca**

**Editors note: Check for the html
version on MusicTherapyToday.com
(November 2005)**

This morning we'll explain the work made with 300 three years old children of the primary school, carry out in a period of eight months (October-May 2003) in a territory of 13 towns of Sorrento's peninsula. The music therapy project became as a part of a bigger project called "Da città a felici-città", sponsored by Regione Campania, that included various intervention, like: association for young people, possibilities to entrust disadvantaged children, possibilities to help the families in their educational project, and, finally, with a project to train the children to read stories.

The music therapy project was presented as a possibility to develop the children's expressive and creative needs, giving them the opportunity to experiment, and then to transform, the educational contents in new expressive forms.

So, for this reason, the music therapy proposals had these aims:

- to train the abilities to discriminate various musical timbres;
- to extend creative abilities through musical improvisation;
- to facilitate children's relationship;
- to prevent hyperactivity.

Music therapy work schedule and equipe.

The music therapy sessions were established in three times each week, for a length of 1 hour and 30 minutes, involving two music therapists for each group of children and the teachers of the class. Totally, the number of the music therapy groups was 13, and the number of children for each group involved in was more or less 24, included one child with handicap.

Project general details

The music therapy activities included monthly meetings between music therapists, Supervisor and the teachers of the group, to coordinate the intervention plan's and to relate it to the children syllabus.

The music therapy project was plan, coordinate and supervised by Gianluigi di Franco.

This project was inspired by some theoretical principles, like:

- ISO and Intermèdiary/Integrative musical Object concepts, from R.O. Benen-zon's theory model;
- Sonorous communication's element;
- Orff methodology

Musical Techniques

- improvisation
- matching
- mirroring
- listening
- imitation
- dramatization
- rhythm and movement
- music and relax
- composing song

General Aims

The music therapy intervention focussed on:

- attention's difficulty
- concentration's difficulty
- listening's difficulty
- relationship difficulty
- growing up personality's difficulty
- to carry out anxiety and transform it in a creative activities
- children school adaptation inside of the classroom atmosphere
- self-government problems

More specific Purposes

To reach these aims the music therapy intervention based all the activities on purposes like:

- to improve cognitive attention
- to improve concentration
- to improve listening
- to improve relationship
- to prevent problems like: depressed state, shiness, stutter, and the problems connected with the growing up personality
- to facilitate growing up creative abilities through musical elements, particularly rhythm, melody and harmony
- to improve connection between sonorous stimulus and children reactions to it
- to improve musical production's capabilities
- to improve self independence from context and to transform stress made by the context through sonorous communication
- to improve tolerance towards children's removal from the mother
- to improve connection between motor and psychic aspects through musical language

Practical activities

- to facilitate musical intensity discrimination (piano and forte)
- to facilitate musical andamento discrimination (lento and veloce)
- to facilitate musical timbre discrimination
- to facilitate mental representation through vocalic and instrumental onomatopoeic sounds
- to facilitate group integration through rhythm and movement
- to facilitate group integration through polyphonic ensemble
- to facilitate mental representation through sonorous dramatization
- to facilitate songs composition
- to facilitate frequency sounds discrimination

- to facilitate self expression through musical play
- to facilitate group's cooperation through instruments construction

Evaluation methodology

All the music therapists, at the end of single session, filled in a protocol based on items like:

- body's position
- instrumentals choice
- face and body expression
- musical production (intensity, timbre, tone, velocity)
- instrumental use (traditional or not traditional)
- emotions through the music
- rhythmic and melodic interaction
- listen himself and the others
- silence respect
- to contract and to extend musical phrases ability
- sonorous dialogues
- other aspects related with music (painting, dancing, etc)
- group Integrative musical Object

Results

At the end of the Music Therapy project we obtained two types of results.

The first one related to children and the second one related to music therapy sessions teachers observers'.

CHILDREN

They acquired, in progress, from one side at cognitive level, the ability to manage musical language through specific techniques and rules. They also learned the

names of the various instruments, and the possibility to play with the elements of the music (like rhythm, melody, harmony) and also to relate them to their body. In this way, they experimented alternative communication's possibilities, based on emotional and creative levels, and then applied, these new possibilities, to the verbal communication.

The use of the musical language, from the other side also, increased their emotional background, in fact their participation became more spontaneous and more creative and this became evident when they began to suggest new musical play to do with the group or when they chose the activity to do. Moreover, their attention levels and their frustration as resistance level's became highest and these results were very important for the teachers and their job, 'cause the children were more concentrate for the school activities'.

So, this project was a very positive experience for the children, 'cause the goals achieved, like socialization's development, rules' respect, creativity's and imagination's development, etc., were achieved in alternative way, that is the possibilities of the musical language offers.

This work was also useful in the perspective to offer to the Sanitary Institution some suggestion connected to some children disfunctional behaviour. This helped the possibility, in some cases, to give the chance to define a clinical diagnosis.

TEACHERS

Thanks to the Music Therapy project, the teachers could have the possibility to conceive the children's skills and their communication's possibilities in a more creative way and to apply, this new vision of their own students, to the normal school activities that became more fluid and free. Moreover, after few music therapy sessions, the teachers collaborated on with the music therapist and offered their experience to evidence some particular aspects to work on.

CHAPTER 36

*Music therapy in
pediatric heart surgery*

**Torregrossa, Salvatore & Di Franco,
Gianluigi**

**Editors note: Check for the html
version on MusicTherapyToday.com
(November 2005)**

Music Therapy finds excellent possibilities of application as a supporting technique in General Medicine.

The project, theme of this work, has been in progress since October 2001 at the childrens' Heart Surgery Ward of well known hospital "Monaldi" (Second University in Naples).

The aim of this work is the reduction of hospitalization trauma anxiety in children and their families.

Heart Surgery Ward, activated in 1981, has become the reference centre in Regione Campania and in Southern Italy for the care of congenital and not congenital cardiopathies. It is part of the childrens' centre that includes: Childrens Heart Surgery, Neonatology, Pediatrics and Pregnancy at risk. It's a highly specialized centre, able to perform every type of operation 24 hours a day since the first hours of life.

Description of the ward

The Ward is divided into three sectors: Reception, Operating Theatre, Intensive Care. All of them are computerized and connected on-line in order to allow medical and nursing staff to collect data related to the period of the patient's stay in hospital. It's also in progress a connection in videoconferencing with the Neonatal Intensive Care therapies of the Regione Campania.

The Operating Theatre is equipped with modern biomedical instruments with a on-line monitoring of biological parameters and a filming system.

Intensive Care Therapy Ward has 10 beds or neonatal islands and transplant boxes planned for the mechanical ventilation system and the monitoring of respiratory and hemodynamic parameters.

FIGURE 1. The Operating Theatre The Intensive Care Therapy Ward



FIGURE 2. The Operating Theatre The Intensive Care Therapy Ward



The ward has been designed to meet the requirements of the young patients and their families in order to make the hospital as easy as possible. It has 12 beds organized in 4 two-bed rooms plus the bed for the attendant; 2 single rooms plus a bed for the attendant; 2 single rooms with sofa beds. The rooms are comfortable and fully furnished: private bathrooms, TV, telephone, air conditioning system, inter-communication system and telemetry for remote monitoring.

In a large and comfortable play/school room young patients can spend part of their spare time helped by teachers and social workers.

There is a room for scientific-educational activities with a library, a video recorder connected to the Operating Theatre, to watch surgery operations, and videoconferencing. The staff includes 11 heart surgeons and heart anesthesiologists, 2 perfusionists, a ward sister, two secretaries and 15 nurses.

Users

The ward generally welcomes patients from 0 to 18 years, whose stay in hospital is limited to the least necessary period. Admissions are made for both surgery operations and investigations before or after operations.

Mothers can stay with their children 24 hours a day, except the short period after operations as the patients spend it in the Intensive Care Ward.

Setting

For the sittings the ward put at our disposal the play/school room, but unfortunately it doesn't meet the classical requirements of a room for music therapy, as it isn't acoustically isolated, and it isn't equipped for the didactic and play activities that daily take place there. Room size is 9 X 7 metres. It's provided with large windows that allow a good light inside, while artificial lights come from neon lamps placed on the ceiling. There are two TV sets, a PC, tables and shelves full of toys. In the centre usually there are some desks and chairs that can be removed to have more room for the music therapy setting. There is a large white chequered floor. The walls are predominantly white.

The ward is equipped with Orff instruments and a piano.

FIGURE 3.

Aims

The Music Therapy project in Children's Heart Surgery basically locates the general aims of the work in:

- giving patients and their relatives a protected place ensuring a space where to communicate freely;
- setting a therapeutic relationship through music.

As for the needs related to the type of pathology and to the general condition linked to the hospital stay, they can be listed as follows:

- limiting the hospitalized patient's anxiety;
- working on family anxiety-conducting constituents, not only to process the most incisive aspects, but also managing, in a transformative way, the emotional problems linked to the traumatic events related to the hospital stay and the surgery operation.

For this reason the project includes the presence and the active presence of mothers and fathers at the meetings. They can release their tension and anxiety, addressing the energy processed towards positive actions, through music.

Methodology

The musical therapeutical work methodology, for this project, has been adapted to the context “in itinere”, differently from the lines generally followed by our by Neapolitan School of Music Therapy) and from the settlements of the musical therapy in rehabilitation field. This because, being the stay in hospital , as stated before, limited to the necessary, the methodical intervention, in a short and long term course, is not possible and the process of changing targets must be done in a single sitting.

Group meetings and/or individual meetings are provided, considering the needs of the patients and their age (0-3 years; 3-12 years; over 13 years).

Meetings take place from September to July, twice a week, and last for about an hour. At the meetings the therapeutical couple therapist-co-therapist is provided. In particular, the therapist has the responsibility of a more directive approach and he is the reference point for the patients, managing the use of the words. The co-therapist, instead, puts into practice the therapist order, providing for a sound interface to the rest of the group, and acting as a resounding element during the activities, while he is a simple observer when the therapist gives instructions.

Methods and techniques

Methods utilized are mainly:

- Listening,
- Improvisation,
- Re-creation,

where Techniques of:

- empathy (imitating, synchronizing, reflecting, amplifying)
- structuring (rhythm base, tonal centre),
- eliciting (repeating, exemplifying, creating spaces, inserting),
- new Address (introducing changes, distinguishing, modulating, calming, intervening, reacting),
- familiarity (sharing instruments),

- procedure (enabling, changing, pausing, receding, experimenting, directing),
- emotional exploration (containing, dubbing, make translations)

are used. (*K. Bruscia – Modelli di improvvisazione in musicoterapia, Ismez, Roma from K. Bruscia Improvisational models, Barcelona Publishers*)

Assessment

For the assessment and the “in itinere” check of the project, an observation protocol of each sitting is filled. This protocol includes:

- opening interview to get quality and quantity information on the physical and emotional conditions of the patients
- observation file and assessment of the musical and emotional-relational parameters
- closing interview, following the activation, aimed to get quality and quantity information about the physical and emotional conditions of the patients after the sitting.

Moreover a fortnight’s meeting is held by the music therapist supervisor to test the project.

The Manager of the Hospital and the Medical Staff are periodically reported.

Each meeting is filmed, by previous agreement with the patient’s family.

FIGURE 4. The setting ready to start the sitting



Subdividing the sittings

NEW-BORN CHILDREN'S SITTING (0-3 YEARS)

In the first sittings, the new born children were often left in their mother's arms to enjoy the simple sonorous massage coming from the music of the older children, mothers and therapists; in the sitting following the division in ages the new born children have had a very prominent role, spurring us to experiment to improve our approach to their needs.

In this way, from the initial sound chaos we offered them in the mixed sittings, progressively, we have decided a subdivision of the sitting as it follows:

- interviewing and drawing up of the protocol's first part
- spoken directions
- listening through receptive improvisation at the piano
- activating
- filling the protocol final part

- possible discussion

Surely the receptive improvisation allows a better control of the listening activity and gives the chance to suitably direct the sound stimulus as regards mothers and children's needs. The initial listening, organized in such a way, has always lowered mother's anxiety level, often allowing them to recover a control and playful dimension, and to explore their children body also related to the suffering and pain.

We had mothers that , during the listening, caressed the surgery operation wounds, checking them while playing, and joking with their children, smiling and recovering a remarkable and serene intimacy. In the active part of the sitting they helped their children to play, taking their hands with the drumsticks, in this way showing they reached a good level of calm; they felt easy and this allowed them to feel free to explore and express themselves in the protected setting.

It was clear that they elaborated tension and the recovered energy used for positive actions. The relaxing dynamics in mothers, (also watching their children's facial expressions, who got more serene, while listening music) had effects on the children lowering, almost always, anxiety levels.

My feeling, developing and executing these receptive improvisations, is like getting in emphatic touch with the new-born children and their mothers, as I can consider the children's faces like a score to read. An empty stave on which I write everything I want to play, or a written stave, since I interpret the children's expressions and consequently, receiving these sensations at an emphatic level, I give them and their mothers the same emotions filtered and elaborated by the sound, and consequently, less anxiety-inducing and more acceptable. Through this model of sitting, mothers have, almost usually, taken a containing role or, alternatively, a fluidifying one, but positive and sufficiently good for their children. A mother that hugs her child and plays with him, while she is rocked by music is as positive, as the mother that takes action.

We observed that mothers' role is completely different in the various sittings, according to the children's age, and it's surely a discriminating factor for the success of a single therapy.

Sitting of children over 3

After the division for ages we had the chance to organize both group and individual sittings for these children.

The idea was to organize the work in a more directive way following the plan below:

- interview and drawing up the initial part of the protocol
- spoken directions
- listening – warming up
- brainstorming to recover elements of the sonorous identity of the patient and giving him opportunity to experiment
- improvisation/dialogue in which the therapist collects the musical elements brought about by the patient, elaborating them and giving them back to him by a sound game.
- drawing up of the protocol final part
- possible discussion.

Following this plan we could evaluate the importance of giving the children a definite and clear structure that, strengthening their confidence, has often taken us to some change during the single sitting, reaching the aim to lower the anxiety levels.

In a special way, during the group sittings, these children are often musically active through the rhythm expression, contributing sometimes with simple and sometimes with more complex rhythm patterns.

On a melodic level, we use simple songs (lullabies) or extempore instrument and/or vocal melodies, old songs or songs thought up at the moment.

The co-therapist, playing the piano supports the production, reinforcing, alternatively the melodic part.

Harmony is always received as a guide, an assurance about what they are doing. In this kind of sitting the mothers' role revealed to be really important, different from what it could be in new-born children's sittings. Here mothers often play at the beginning, also driven by therapists, but they are wise enough, thanks to their instinct, to leave the sound part to the children, when they reach a relaxed condition and become propositive in the sound dimension.

Intensive Care work

Since the second year of the project requests for music therapy treatments have been widened by the ward manager also to some Intensive Care patients.

Here I'd like to explain shortly the case of R., a 4 years old patient, in hospital since she was 2, with a diagnosis of Type 2 Glycogenosis.

Glycogenosis is a group of rare diseases, related to the faulty functioning or lack of the enzymes involved in glycogen metabolism. Glycogen is a polysaccharide that acts as a deposit or a reserve for glucose, that is a source of energy for the body. In case of glycogen heap in tissues we have serious organic diseases.

In this specific case the lack of enzyme (acid alfa glucoside) causes a progressive weakening of the skeleton muscles and arrives to involve lungs muscles and heart.

R. has been an in-patient since February 2002 in the Children's Heart Surgery ward for serious cardio-respiratory problems. Later she was included by Prof. Carlo Vosa and the Minister of Health Girolamo Sirchia, in a research protocol for a new experimental american medicine.

Our action, still taking place, started in October 2002.

At the time R. lived in the Transplant box of the Intensive Care. She was tracheotomized and wasn't able to breathe autonomously, she was fed by a nose-stomach-tube. She couldn't speak and was demotivated, not disposed to have relationships with the others. She often appeared scared and her attention seemed to be attracted by the sounds (bip) of the medical instruments she was tied to.

Her requests were, almost totally, to meet her physical needs (aspiration, changing position...).

The music therapy setting was prepared inside the Transplant Box, protecting the therapy room and arranging with the doctors a time in which no other therapy had to take place.

Instruments used are small, not many, but representing the various families. They are put on the bed so that R. can see them and easily touch and catch them.

The first step of the work is aimed to:

- Creating a contact
- Stimulating pleasure and motivation to act
- Stimulating motory activity
- Increasing attention and concentration moments

Methods proposed in these steps were: improvisation and re-creation. Techniques: mirroring, imitating, reflecting, sharing instruments, rhythm base, creating spaces, containing.

The sitting was organized as follows:

- Welcoming song
- Experimentation step: sonorous brainstorming
- Dialogue step: sound games
- Leaving song

After about six months, once her clinical picture improved, she went out of the Intensive Care ward for longer and longer periods of time, and progressively she alterned the staying in hospital with short staying at home, even if she always needed a help of medical instruments for breathing.

During this time the music therapy setting was moved to the play/school room.

Single sittings have been made with her mother participation in order to improve some aspects of the inevitably altered mother-daughter relationship and have also been made group sittings in order to promote and improve relation abilities.

In order to meet her requirements in this step, among the other instruments, the piano had a prominent role. In fact, use of harmonies strengthened and supported vocal and instrumental production in the patient, increasing motivation and the expressive/communicative field, guiding her to the exploration of the emotional level.

At present the sitting is organized as follows:

- interview and drawing up of the protocol first part
- oral directions
- listening - the welcoming song – warming up

- brainstorming to recall the sonorous identity elements of the patient and give him the chance to experiment
- improvisation/dialogue in which the therapist collects the musical elements brought about by the patient, elaborates them, giving them back to him through the sound game.
- drawing up of the protocol final part
- possible discussion.

Conclusions

What we did until today pointed out important changes compared to the initial objectives.

The little patient now seems to be more motivated to act. Her posture is in general more tonic; movement is wider, precise and correlated to the emotional level.

Attention times are better for quality and quantity.

The response times to the sound stimulus are more appropriate. On emotional/relational level the little patient appears more open-minded toward the external world.

Her facial expressions are more expressive and contextualized.

Some statistic data of the project

Intervention time October 2001 – June 2004

Sittings carried out until today n°84.....

New born children (0-24 months)

Children (over 24 Months).....

Music in the oncological pediatric ward - music group therapy for children and for parents

Nehari, M. & Ganot, I.

Introduction

Pediatric Oncology is a relatively new frontier of music therapy. Much of the published music therapy literature concerning the area of oncology appears to have been directed towards adults. (Baily, 1984; Lane, 1992; O'Callaghn & Colegrove, 1998; O'Callaghn, 1996a, 1996b, 1997).

Literature that does exist, however, describes music therapy programs with pediatric oncology patients has demonstrated benefits, particularly in the areas of emotional needs , for example: communication of feelings such as isolation, anger, anxiety, and loss of control (Robb, 2000, Edwards, 2002 & Kennely, 2001, Dave-son, 2001). Also, it can benefit in reduction of pain, at least temporarily (Lowy, McGregor et al. 1997; Standley & Hanser, 1995; Bellamy, 1990; Hadley, 1996; Hinderer, 1995). Grasso (1996) claims that music therapy is widely used with hospitalized adolescents, although little is documented.

Group music therapy with oncological patients is even less documented. We have found surprisingly few papers on group music therapy of adult cancer patients

(Walden, 2001; Bunt & Marston-Wyld, 1995; Corodobes, 1997; Standley, 1992;). Walden (2001) declares "...at the time of this writing there is no research literature examining the effects of group music therapy experiences on adult oncology patients... (p.221). We have found no such literature with children, or with parents of oncological patients.

The rationale for exploring and applying the uses of music therapy within a group setting for children cancer patients and for parents of children who are cancer patients comes from a few different reasons.

There is clear evidence from the literature that group work, in a wide variety of situations, is an effective means of reducing anxiety and fear while offering support and reassurance, for children as well as parents.

For oncological children there is very often a lack or minimization of social activity and relationships with peers, because of the stigma of the illness, the long and harsh treatment and the necessary isolation periods, due to medical reasons.

The value of music as means of social integration beyond words has been stressed early in the development of the field of music therapy. (Gaston, 1968).

Finally, group work, instead of individual attention, is obviously much more cost-effective.

The aim of this paper is to describe an innovative program of groups music therapy developed in Safra Children's hospital in Sheba medical center. It is believed that music therapy intervention offers children with cancer and their parents a psychological experience of well being and support, and that the group setting would magnify these psychological experiences.

The program design

The Pediatric oncology center consists of a hospitalization ward, where the children are hospitalized accompanied by their parents day and night, and a day hospitalization clinic.

We decided to open two groups of music therapy: one for the children in the day hospitalization clinic, and one for the parents of patients in the ward.

The children in the day clinic come for a few hours of treatment at a time, where – after having blood taken for tests, they are connected to infusion poles, sometimes with several different infusions. Most of them, most of the time, are mobile and can move around with their poles. They are often angry, sometimes hurting, with little control over what is being done to them. The children in the ward are often too weak to leave their beds and can only receive individual attention in their beds. Their parents, however, who are “hospitalized” with them are “cooped in” the ward, worried, angry and lonely, away from their natural social support circles. They are constantly occupied by the sick child’s needs and wishes, often very tired physically and emotionally.

THE REVOLVING-DOOR GROUP FORMAT

Planning the two groups : the one for the children in day treatment and the other for the “hospitalized” parents, we searched for an appropriate group format. First, we considered the more classic and conventional type of groups: a structured support group with a fixed number of meeting, or a dynamic ongoing open-ended therapeutic group. In both formats the dynamics of the group itself and the relationships among the participants are of the outmost importance in the therapeutic process (Yalom, 1995).

While deliberating the question, we soon discovered that neither type of group was adequate or possible for out patients’ needs. The parents wouldn’t and couldn’t undertake to come themselves or bring their children to group meetings in a specific day or on a specific hour. Their whole life is so organized around the illness and its physical treatment that it is virtually impossible to take more commitments regarding time. How will the child feel at a certain day? Will they be hospitalized? Will he have to go through a certain medical procedure? Will the parents fall asleep after a sleepless night? Will they have to be with their other children? So, we chose the revolving door group format.

The revolving door group format is based on the idea that the therapist, the time and the place of the group are constant and known; the group participants change and the participants are invited to come to the group whenever they can. The group, therefore, includes different members in different sessions. At a given sessions, some of the participants have attended a few sessions and for other participants this may be the first one. Participants may attend the sessions on an almost regular basis for a while, then they may seemingly drop out, only to come again a month or two later.

We have had our two groups work like this for almost two years now. All parents in the hospitalized children ward, know of the time and place of the parents' group, and if they can – they come to the meeting. When necessary volunteers from the ward watch over the ill child while the parent is participating in the group. The group takes place in a room on the ward so the parents are close to their children and can come to them immediately if needed, for example, when the child cries or the physician needs them. The children's group takes place in the day clinic, so a nurse can walk in the room and replace an infusion bag, if necessary, without interruption to the group's work.

A delicate balance develops between the group and the individual participant. Although there is no "group" in the usual sense of the word in theory and practice of group therapy, and the group, as such, does not develop and may be a different "entity" at each meeting, the sharing, the interpersonal interactions and the togetherness are an integral part of the therapeutic work.

The parents' group

As mentioned earlier, the parents whose children are hospitalized are in a heightened state of alert and worry over the children's feelings, moods and medical needs. They experience apprehension, stress, physical discomfort, feelings of seclusion and loneliness and often are physically and emotionally drained. We therefore decided on three main goals for the group:

1. To invite parents and 'give them permission' to get out and away from the 'here and now' of the hospital to somewhere far away on the globe to a place that is safe and good for them or to another time that is good and fun. They are invited to do so in their imagination, with the music. Those imaginary trips around the world are taking place while the parents are only a few meters from their ill children.
2. The second goal was to invite parents and 'give them permission' to go away from the 'here and now' of taking care of their children. With the music and in the imagination they were invited to focus on themselves - their needs, their bodies, their emotions.
3. The third goal goes in the opposite direction, namely to invite parents and 'give them permission' to be with other parents: to share the 'here and now' of their experiences, to give each other the permission to concentrate on themselves and also simply to know each other and touch one another with our music.

The mode of music therapy used in the group was passive listening rather than using instruments or improvising. This was done partly because of space limitation (the size of the room) but mostly for two other reasons:

1. To allow parents to experience a state of being vs. a state of doing, which they experience while catering to their children's needs.
2. To overcome the problem of shyness, which in a revolving door group format comes up in virtually every session.

The parents' group sessions

Following is a description of typical proceedings of a session and examples of participants' work and relations.

Activity 1 (2-5 minutes)

When there is a new member in the group, the therapist and the group members introduce themselves.

Activity 2 (5-6 minutes)

Deep relaxing breathing exercise. The parents are invited to focus inside themselves, to listen to their bodies, to slow down, to be, not to do.

Activity 3 (10-11 minutes)

A geographical-cultural musical journey. Three different musical passages presenting different places on the globe, different times, or cultures are played. The parents are invited to listen to the music and let it take them wherever it does, then share with the group their reactions to it. "I had a feeling of vastness and awe". "There was mystery and loneliness." "It sounds like Indian Music of monks – it gave me serenity and quiet". "This has something to do with holy prayers. It is so relaxing". "I feel like my whole body is vibrating I have no idea what the language is." Darbukka drumming peace sent a parent time traveling to the past back to her carefree happy childhood in Morrocom and Hassidic music sent another parent, religious orthodox, to the future, to a fantasy of happy times, a wedding celebration for her dying son.

Activity 4 (20 minutes)

“The Virtual private journey” – The activity consists of an imaginary journey, this time actively led by the therapist, while listening to relaxing and compelling music. Sometimes the participants are invited to add movement to the music : delicate minimal movements of the shoulders, necks, wrists, ankles, feet, so that the body also participates and areas of tension are detected and dealt with.

The Participants are invited to be passive, to be taken care of, to be rocked gently and soothingly into a place and a time and a state of well being and of rest. The music not only takes the parent to another place and time, it helps them stay there after the music finishes. Each participant is touched through the music by the others in the group wherever he or she is.

The children's group

The children are connected to tubs and infusions, they have very little control over their bodies and often feel passive victims of the “things” that are happening to them and done to their little bodies.

We therefore decided on three main goals for the children group:

1. To invite the children to be active and to be able to choose to be away from their usual passivity and tedious treatment routines.
2. To invite the children to spend time away from the sickness and the sense of powerlessness into activities of enjoyment, fun, with a sense of power.
3. To invite the children, some of whom have not been able to go to school or kindergarten for a while, to be together, to experience company and cooperation with peers; to talk to each other, share playfulness and even if for a short a short while – distance themselves from seclusion and loneliness.

The mode of music therapy chosen, was active creation of music, playing instruments, conducting or accompanying taped music.

THE CHILDREN GROUP SESSIONS

Following is a description of typical proceedings of a session and examples of participants' work. It should be mentioned that there was flexibility allowing for variations in the sessions, depending on the children's ages. The age of participants ranged from 3 to 10 years. Parents of young children were allowed to stay in the room with them.

Activity 1 (2-5 minutes)

Introductions: The therapist and children introduced themselves to the group. Sometimes the therapist did the introducing for a shy child.

Activity 2 (10-15 minutes)

Warm up and preparation for active participation: This activity begins by introducing some interesting and unfamiliar instruments, whose origin is exotic countries, for example South America or Tibet. This is done to focus the children and to captivate their interest. When possible, children who are already familiar with the instruments introduce them to the new comers.

The instruments are displayed on a table, so that the children can choose which one they want to try out first. They have control. The instruments are all percussions (for example, agogo, nails of Alpakas, Tibetan gongs, Kabasa, etc.) Wind instruments are excluded, since the kids' immune systems are vulnerable and the instruments should not be passed around. The children, depending on their age, are then invited to play the instruments, try them out, create their own sound. This is important in allowing them to have a sense of control and of activity as well as having fun. The children are asked to close their eyes and listen to each one of them make sounds and guess which instrument produced this particular sound. They are encouraged to communicate, share and cooperate.

It is always amazing to watch the children's body language change as they play. Children who are fearful of moving their hand that was tied up to the tubes or infusions forget their fears, pain and caution and move their hand freely, joyfully.

Activity 3 (10-15 minutes)

Active participation, the orchestra: in this part children are asked to choose an instrument and accompany a rhythmic taped piece of music. Taking turns, one of them is the conductor of this "orchestra". They are active, they "create" music, and they cooperate and are involved with each other through the music. They have fun, they control much of what is happening, sometimes a child might even get up and dance to the created music.

Activity 4 (10-15 minutes)

Passive listening and closure: this activity involves a relaxation induction and closure. After children have exerted energy through active participation, they are

invited to sit down again and listen to music. Various possibilities exist, two of which are playing songs that children ask for individually, or playing beginnings of well-known tunes which children are asked to identify. Familiar tunes enhance feelings of safety. As there might be children from different subcultures (very orthodox, or of Asian or Russian origin, for example) a repertoire of familiar songs is accordingly prepared.

Discussion

Our aim in developing the music group therapy program described above was to help the development and maintenance of psychological well-being during a serious illness of cancer. Traditionally research about psychological stress focused on the psychiatric symptoms, such as depression and anxiety. But the emphasis on such symptoms tells only part of the story about how people cope with serious illness, and how we can help them psychologically. The other part of the story focuses on psychological well-being and coping processes that support it. The idea is that people can experience psychological well-being even during difficult times. (Folkman & Green, 2000; Folkman, 1997; Chesney et al., 1996; Zautra et al., 1990). We believe that not only can they experience well-being despite serious illness, they actually need it to fight the illness and carry themselves through the hard times.

In our conceptualization of the music group therapy program we used Folkman's (1997) model of stress and coping, which is based on the Lazarus & Folkman model (1984). Regarding coping mechanisms in this model, Folkman suggests three kinds of coping modes: Problem-focused coping, Emotion-focused coping and Meaning-focused coping. Folkman & Greer (2000) state that high control is associated with higher levels of problem focused coping behavior such as information search, problem solving strategies and direct action to solve problems. Less control is associated with higher levels of emotion-focused coping such as escape, avoidance, distancing and social support.

Problem and meaning focused coping mechanisms include cognitive reframing such as reappraising the situation as providing benefit, acquiring a sense of greater strength or competence, increased self-esteem or self worth or developing a sense of coherence about the meaning of one's life (Antonovsky, 1979;1987, Affleck & Tennen, 1996, Lazarus & Folkman, 1984; Moskovitz et al. 1996, Folkman & Stein, 1996). A more action oriented approach of coping mechanism included redefining priorities and setting new goals. These processes enhance a sense of personal con-

trol and mastery, a sense purpose and meaning and goal directed coping. (Emmons & Kaiser, 1996; Moskovitz et al., 1996; Taylor & Armor, 1996).

When speaking of psychological well-being one usually refers primarily to positive affective and positive cognitive psychological states” (Folkman & Greer, 2000, p.13). We believe that more emphasis has been placed on the importance and benefit of the cognitive, behavioral modes of coping with stress, compared to emotional modes. The main issue of those theories and research has been that people feel better when they have goals that are meaningful to them, for which there is a plan of action, and for which there is a reasonable probability of success. From those models recommendations regarding therapeutic programs were adopted.

Emotion-focused processes have been less researched and we suspect that they are regarded to be less desirable and less effective. But for cancer patients and their families, for whom the treatment is very long and painful, and a sense of control can truly be only partial, the cognitive-behavioral mechanisms of coping, important as they are, may not be enough.

Even when successfully implemented and used, the problem focused and meaning based processes, leave the patients and their families with days, weeks and months, sometimes years of pain, fear, loneliness, exhaustion and suffering.

We therefore, argue that the category of emotion-focused processes have not been integrated enough into the system of important and useful coping mechanisms that enhance and support the well-being of the individual in distress. We want to emphasize that we think of this category as an important component of an integrated wide range system of varied coping processes.

The emotion-focused coping mechanisms enable people to take “time out” and “time off”, which are periods of escape. Those escape periods allow for psychological rest and recuperation. Being with others who are traveling the same difficult road allows for emotional social support that, like the other emotion-focus mechanisms, enhances psychological well-being. Those mechanisms allow not only for respite and gathering of psychological strengths, but they also help motivate further coping and carrying the heavy emotional and psychological burden for the necessary extra miles.

Conclusion

The music therapy group program that we developed proved to be an intervention that helped sick children and parents benefit from and develop those emotion-focused strategies that helped, together with other coping mechanisms, carry them through the difficult, painful stages of treatment. Not only could they benefit from recharge of emotional energies during the sessions, they also learned to use those process between sessions, at their convenience and when the need arose. They were encouraged to share their experiences with fellow parents, or fellow patients, at the level of exposure and intimacy that was comfortable for them. Parent received and took permission to focus, temporarily, on their own needs and take time for themselves; children learned to “take leave” from the imposed passivity during treatment and from their isolation and pain, and enjoy actively collaborating with peers, having “time out” of fun, laughter, some control and exploration of new territories.

The therapy program described in this paper goes along with other works emphasizing the need for maintenance of psychological well-being for patients with cancer and their parents. We have focused, however, on therapy that enhances emotion-focused coping rather than the more common cognitive-behavioral focused therapies. We feel that the emotion-focused processes are less researched, less used or at least less documented in the literature. The revolving door group mode allows for being with others at a time when making commitments on time is almost impossible, or at least unwelcome. This mode of group intervention accommodates the huge demands on time, that parents have during treatments as well as the difficulty they have to control their time commitments. We believe that the revolving door group mode is especially suited to non-verbal means of being together. It allows for safe togetherness, for sharing at a comfortable level of intimacy and for being with the group and focusing on oneself in a way that a verbal group cannot provide.

Regarding this program there are two issues we would like to see further studied and developed. The first question concerns the way of evaluation of the effectiveness of these interventions. We would also like to see more research about the effectiveness of the revolving door group therapy format.

The Second question relates to developing effective ways of reaching out to participants of revolving door groups. We think that more children and parents could benefit from the group, but maybe we didn't get to them or they didn't find their way to us.

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CHAPTER 38

Why did I do that?

Nye, Ian

Introduction

When our clients play music, we have an infinite number of choices as to how to respond. Do we play or not play? If we play, what do we play? What influences how we play? And outside sessions, how do we talk to colleagues, parents and other people about what we play any why we play it? Gary Ansdell calls this difficulty “Music Therapists dilemma”, and he says that it

“...follows from having to use verbal strategies to talk about musical processes...Unlike psychotherapists, however, our (verbal) descriptive/explanatory discourse is not the same as the (musical) language we work in.” Ansdell (2001: 2-4)

In my notes, I write about ideas like “turn taking” and “framing” a lot, but what exactly do I mean by them? How do I achieve “framing” or “turn taking”? Why is it important to know how or why I do this? These are the questions I will be looking at today.

My paper today is in four sections.

1. This brief intro
2. Look at some of these words and some of the technical detail of how I achieve them with some clinical extracts
3. Some thoughts as to why it is important to be aware of these ideas and ways of playing
4. Some more extracts from one child, showing how my music changed over time and the thinking behind why I felt I needed to change what I played

I will now move on to the second section and look at some of the words I use and how I achieve them.

Section 2

I will start with “copying”.

Few words re Tony’s book

I copy when I am using the same or similar instrument to my clients, and literally do the same as they do. If we are playing different instruments, such as the client on the drum and me on the piano, this would not be copying as my response would involve elements of melody and harmony which are not possible on the drum.

Of mirroring, Wigram says “*Mirroring: Doing exactly what the client is doing musically, expressively and through body language at the same time the client is doing it. The client will then see his or her own behaviour in the therapist’s behaviour.*” He goes on to say “In order for the mirror to be exact (which is what I mean by a copy), the therapist may also need to pay attention to using a very similar instrument as the client in order to achieve a mirrored response.” Wigram (2004: 82)

I feel copying has very limited uses in a therapy session. When talking about “reflecting” Bunt and Hoskyns warn “A negative aspect of this technique is the potential slide into parroting with the dangers of sounding like an automatic response”. I feel that the same is true of copying. It is easy to get stuck in copying and then it can become unclear as to who is copying who.

So I usually use a copy as a starting point from which to move away as quickly as possible, and as a place to return to should we need a re-start in our music.

I want to look now at turn taking. Unlike copying, I feel turn taking can be on different instruments, but here I feel the key is that each turn must make reference to the previous musical gesture by the other person. I feel that a verbal analogy can be drawn here as turn taking is akin to a conversation. A conversation is usually a gesture followed by silence so that the other person can have their say. Within this verbal model, each contribution relates to the previous one, and a sudden change of tone of voice or subject matter creates a surprise or confusion. I feel that all this holds true for a musical turn take.

Wigram says of “*Turn-taking dialogues: Making music together where the therapist or client(s) in a variety of ways, musical or gestural, can cue each other to take turns. This ‘turn-taking’ style of dialogue requires one or other to pause in their playing and give space to each other.*” He continues “To liken a dialogue to a conversation is probably the nearest and most understandable way of describing this process.” Wigram (2004: 98)

To highlight what I’ve said about copying and turn taking, I wish now to play my first extract. Here you will see me and a young girl playing the drum which is between us on the floor. She starts out by hiding her face from me, and as I wait for her to make a musical gesture, she slowly moves her hand forward and touches it with the tip of her finger, and the sound she makes is barely audible. Feeling that she needs reassurance to carry on, I copy her in almost every detail – the number of times I play the drum (once), I use the tip of my finger, but I play just a fraction louder. She plays again, tentatively at first, but with increasing confidence. I immediately play with two beats, and then three so that I am no longer copying her but taking turns with her. As we continue to take turns, I try and play in different ways to show her that it is ok to do so, and also so the music is not just two people echoing what the other one does. When I feel she is getting anxious again, I go back to one copy, although here too, even though I copy the musical elements of her playing, I still try and do something different, for example, one time I use two hands instead of one. All the time I am assessing how much variety I can add to my playing, or whether she needs my music to be quite similar to hers.

EXTRACT 1

I try and use turn taking when I feel that the client needs help separating me out from him or herself, or reassurance that that separation is manageable. I feel that I am trying to create situations where it is clear that there is a client ... and therapist, but also that there is a link between us. I feel that turn taking helps as each turn is related to the previous one, creating a musical link, but that there are clearly defined boundaries between our musical turns.

When I am taking turns with a client and I am playing the piano, I think a lot about harmonic tempo (by which I mean how often the harmony changes). In my second extract, I am playing the piano and singing in turns with a client. I try to not change harmony when he is singing, but when I sing. This is so that there is not too much happening on his turn to distract him from hearing (or understanding) our turn taking.

I do not stick rigidly to a harmonic tempo though, and I do move the harmony on when I want to see if he can tolerate that and carry on vocalising with me. But here too, if I feel I did too much, I will revert to just one chord until he sings again. An example of this comes towards the end of the extract when I leave a dominant seventh chord hanging in the air for him to complete. So like the previous extract, I am always wondering when I can push the music on, and when I need to hang back. In the previous extract, that was in the context of how many beats I play and how I play them. In this extract, I am thinking about developing the music in terms of harmonic tempo.

I also feel that I am gently supporting his singing and providing a musical context for his vocalisations. To make that context as accessible to him as possible, I try and use very simple progressions that cadence regularly. In this extract, the chord progression is initially just 2 chords, but then I extend it with a surprise chord, but the client carries on vocalising. I make sure though that I continue to cadence regularly so that the music does not lose its shape.

EXTRACT 2

I mentioned just before that last extract about providing a musical context for the client's sounds. I'm going to look at this in a bit more detail now.

I am going to show you an extract of work with a young girl where I feel that she produces lots of sounds, but they feel quite random and unconnected, so I feel that I want to offer her a context in which these sounds start to be connected to each other and to my music. I think of this as "framing", or another way I think about it is that it is as if I am providing the canvass for her to sprinkle her sounds on which are like tiny dots of paint. (My use of the word "framing" is a slightly different use of the term "frameworking" that Wigram also talks about in his book. It is more akin to the terms "grounding, holding and containing" he discusses.)

At the start of the extract, you will see her making a few sounds at the top end of the piano. I take my tempo from her playing, and my playing is gentle, but rhythmic.

The gentleness I take from her playing, but her playing lacks much rhythmic form, and I feel this is what she needs from me.

I hope that through having her sounds framed within my music, the potential for each musical experience to be linked up to another one can be increased. This is so she begins to experience her sounds as parts of a bigger whole rather than single experiences in isolation from each other.

Turning to Wigram, he says “*Grounding: Creating a stable, containing music that can act as an ‘anchor’ to the client’s music.*” and thinking of when these techniques are useful he says “Grounding, holding and containing are all therapeutic methods that are extremely useful when applied with clients who have a very random or floating way of playing, and way of being. It is helpful where the client appears or sounds unconnected to their music, or the music lacks any stability, direction or intentionality.” (Wigram 2004: 91)

Earlier on in the therapy, I found that my playing lacked much rhythmic clarity, and was as vague as her playing. This resulted in her sounds still sounding random and lacking in form as what was holding them together (my music) lacked the necessary grounding and stability to act as an anchor. But, providing her with a stronger pulse gave a clearer context into which her sounds could be put.

When she plays, I tend to play a replying melody. The music cadences often, but where this extract differs from the last one I played is that as the music progresses, I feel I am doing a lot, and not waiting for her in the same way I waited for the boy before.

EXTRACT 3

In my final extract of this section, there are many factors influencing how I respond to the child. Firstly, I am looking to take turns with him as I feel we are very merged, both physically and musically. But I am also aware of just how much of what he expresses he can bear to hear me give back to him. If I give his music back to him in quite a similar form to the way he gave it to me, it will result in the music stopping, and he will either push himself into me, hit me, scratch me or kick me. But if I try and frame it gently, I feel we are avoiding any emotion in the session, and I end up over identifying with his need to not hear his own feelings reflected back to him. So I am always trying to gauge just how much emotion to put into my playing.

We are sat at the piano, and I am right at the bass end – partly because where the client is sat, and also because I always keep open the option of jumping out of his way so that I can avoid a punch or kick!

I use octaves and open fifths in my playing as I feel this way of playing can both provide a musical context within which his note clusters can be heard, and also express something of the strength in his playing. He frequently puts his head down onto the piano and pushes himself into me. When he does this, I hold down my last note so that the music does not move on and overwhelm him, but there is something of what he expressed held in the music. You will also hear him pressing the sustain pedal down a few times.

When he does play, I play an answering phrase to him, and when he sings, I sing back to him. All the time, I am looking for the chance to take turns. Following a period of quite loud turn taking, he plays an extended phrase on the piano. So to carry on the momentum of the music, I try and play at the same time as him. This does not last long though as I play at double his tempo, and he soon stops. (You will hear me play de-de-dun, de-de-dun.) So I return to turn taking.

But he then strums the guitar, which leads to us taking turns very firmly on the piano. It is at this point that I feel we are together in the music and in so doing enabling him to express something quite strong in a way that is safe for him. Yet at the same time we each have our separate contribution to make to the music and so we have not merged together to avoid such an expression, which is what I feel he does when he puts his head down and pushes into me.

EXTRACT 4

Section 3

So, that was a look at some of the words I use to describe the music in sessions, and how I think they are applied in a clinical setting. But why is it important to be aware of all this? Surely we just play spontaneously in response to our clients? Does it really matter if we take turns or provide a frame? And besides, some of the music I play does not fall into a category that easily, nor do I necessarily stick to one kind of response for very long? So why all the fuss about naming or labelling how we play?

I see a variety of clients with a huge array of needs. One way of playing will not suit all the needs of all those clients. And as our clients progress through therapy, their needs will change, and so we need to adapt as our clients do. To make best use of our music for the benefit of our clients, we need to be aware of what our clients need from music therapy, or what music therapy can do to help them. We therefore need to be flexible in our approach to our clients, which means being able to respond to them with sensitivity and spontaneity, and having various improvisational techniques at our finger tips which we can employ at any time within sessions.

To try and meet those needs, I constantly ask myself various questions within my thinking. Is there something I can say to this child in the session that will help them? Can I change the layout of the room or change the instruments in here? If I have an assistant in the room, is that helping or hindering the client? Does the child need me to sit or stand, be closer or further away? Is the position this child is put in for the session suitable, especially if they have limited movements? But the first question I always ask myself is how can I use my music to help this child? How do I perceive the needs of this child and how can I use music to address them?

This is at the heart of what I want to say today. The needs of our clients will vary and we need to keep those needs in mind as we work with each client. We need to be aware of the different ways we can respond to our clients, and naming the kinds of responses we can offer helps me to think what kinds of music might be helpful for them. I hinted at this with all my extracts when I said why I played the way I did, and how my thinking was influenced by their needs as I perceived them and how I felt music could attend to them.

This approach reminds me of Rachel Verney's model of thinking – listening – doing which she presented at the joint BSMT/APMT conference in London in 2001. I've mentioned how I question what I can do or change, musically or otherwise, or even, NOT do, which would help them. But then you come to the session, and you actually have to play the music. In listening to their playing we get clues how to respond, and so I think that the doing is a combination of the listening and thinking. This is where our thinking outside the session meets the listening inside the session, and combines with our own musical identity and skills which results in our playing.

Within this model, if there is no thinking that can incorporate different ways of playing, and a sense of how those different ways of playing will affect different clients, then the doing will be the poorer for it. We would run the risk of just playing with our clients, over identifying with them, and colluding with their defences.

This was important in my work with the girl from my third extract where I was being rhythmically very deliberate. I had previously been unclear with my sense of pulse, and the girl needed me to be strong rhythmically. I had over identified with her music, and needed to step back and think what way of playing I could provide for her to enable change in her.

I do want to stress though that I do not think that there is a correct way of responding to any particular client. All our musical identities are different (based on our musical upbringing and experiences, exposure to different kinds of music, and preferred styles of playing), so how each therapist responds to his or her clients will be unique to them. My point is that we need to know what music therapy has to offer our clients, how we can use our own music to help them, and then combine this thinking with our listening and musical selves to try and affect change in our clients.

A further point I wish to emphasise within this model is that whilst I feel that a certain way of playing might benefit a client, it does not mean that I have to stick rigidly to that type of response. I mentioned flexibility and adaptability earlier, and this holds true as the music unfolds and develops in the session. In my first extract where I was playing with the girl on the drum, I used copying to start with, and as a place to return to when the music overwhelmed her. But I quickly moved on to turn taking, and as our playing continued, so I was thinking about how far I dared to adapt my music.

Without a sense of the different ways I can respond when a client plays to me, and how those responses may or may not be suitable at that time, I feel that I would not be meeting the needs of that client to the best of my ability. It's as if I would be only offering a limited selection of the kinds of music we can play together, seriously restricting the potential of the therapy.

Rather typically for this paper, Wigram touches on most of these points I've discussed in this section in one neat paragraph! It is an extended quote, but I've included it here in full.

"Therapy methods can either be used intentionally (or intuitively) in therapy work with clients or they can be the objects of analysis when reflecting on a period of free-flowing improvisation to explore what was actually happening. It is not usual for music therapists to pre-plan exactly the method they might use, unless they are working in an activity-based model, or with a structured assessment procedure. In improvisational music therapy, particularly, the model requires an adaptive and flexible response to the way the client begins to make music. There can be a certain

degree of planning based on the assessment that has taken place and an estimation of the client's needs and the objectives of therapy that will promote certain techniques above others. However, it is more typical that improvisational music making occurs, and within that music making intuitive judgments about therapeutic method are made based on the 'here and now' experience. Music therapists don't remain exclusively attached to one musical technique or therapeutic method for a set period of time, and might fluctuate between a number of different methods (as well as musical techniques) over the course of a single improvisation." (Wigram 2004: 81)

I will now move on to show you four extracts from work with one child, to highlight how the music I played changed over time.

Section 4 – Case Material

"Musical empathy is not just imitation or parroting but a subtle dynamic process". So write Bunt and Hoskyns (2002: 39), and this is relevant to my work with M.

M is currently fourteen years old, and we've been meeting once a week for about two years. You will see that he has many difficulties resulting in limited movement and fine motor skills, no speech (although a powerful and expressive voice), and is a wheelchair user. I see him for his sessions in his wheelchair and he sits in front of a keyboard and I put the chimes on his left hand side. You will see in later extracts that there is a guitar attached to a heater on his right hand side.

The first extract comes from an early session and here I tried to match most of what he played. I've not mentioned "matching" yet, but I think that matching is where we take all the elements of the clients music – tempo, tonality, dynamic, timbre – and play in a way that is the same in as most of these elements as possible. This is not to say that we just repeat their playing, we might choose an element to be slightly different so that might draw it out of the music and develop it.

Wigram says "*Matching: Improvising music that is compatible, matches or fits in with the client's style of playing while maintaining the same tempo, dynamic, texture, quality and complexity of other musical elements.*"

M played lots of note clusters on the keyboard (due primarily to his fine motor difficulties), and so I decided not to match that. But what I would do was try and find a key and tempo from the clusters, and then echo fragments of his playing. For

example, if he played just two neighbour notes, then I would echo those, or if he made a leap, I would echo that. When he made a throaty noise (a sort of “rrrr” sound), I would play much louder in a tremolo pattern, and if he sang, I would sing back to him.

I did this as I wanted to show him that I was listening to him and that I was available to him, and that whatever he played was ok.

However, in the sessions, my mind was so full and I felt I was thinking a million things at once. In my notes, I wrote about how I was concerned that we were not listening to each other. Looking back now, I see just how busy the music was, and that there was no chance of us hearing each other. Note how there are no silences, I play through them all.

EXTRACT 5

Gradually I realised that matching was not the best course of action and that we both needed to slow down if we were to start hearing each other so that we could share a musical relationship. I was still concerned as to how I could organise his music so that it could be heard in relation to the rest of his music and my music. I felt that using key would be difficult due to the atonal nature of his music. So I tried to use pulse as the organising element.

So I used lots of bass pedals in a pulse as a foundation upon which the sound could be built. But I still could not let go of echoing some of his phrases as I still wanted to show M that I was listening, and I was concerned that he would not feel that if I did not refer quite openly to his music in mine. You will see this in my next extract. Note also how I still play through silences.

EXTRACT 6

Around about this time, I had a conversation with a member of staff who worked with M quite a lot and she mentioned how his life was very chaotic. He has an identical twin brother and an older brother, all of whom have the same condition. Home life consists of whoever can scream the loudest gets what they want first, and life in the classroom was quite similar. I was thinking about chaos and our music, and I thought about how I had been playing a lot, and given him lots of musical attention in response to his playing. It also occurred to me how I had started to think about other ways of being with M in our music and that maybe organisation was not what was important, but a sense of time for us to really hear each other and not enter into his busyness with more busy music.

So I decided not to worry about tempo either, and just try and breathe more space into the music, use silence more, so that when we did play, we could really concentrate on hearing each other more fully. If a pulse developed, all well and good, but if not, not to worry about it.

This next extract comes a few sessions later, and again we will pick it up at the start of the session. (Sorry about the quality of the picture – video camera had problems!) M plays a descending phrase on the keyboard and I answer with one note and then stop when he does and there is a silence. M looks round, but still feels part of the music. He then plays another phrase and I play a chord and then a single note and again we pause. Gradually the amount of music increases, but my pulse remains flexible and not rigid as before. I also use tonal music and just as my concerns about organising through pulse have diminished, so has my concern about using a key and the crunches that may occur as a result. A word I used a lot in my notes was “space” – it feels like there is a lot more of it in both mine and M’s music now.

EXTRACT 7

I really felt now that we had slowed down enough to hear each other, and that I did not have to echo fragments of his playing any more.

In my last extract, I am accompanying M’s singing. I’ve not talked about “accompanying” today, so what do I mean by that? I feel that accompanying is where I perceive the client’s music as a solo line, and so I offer a foundation over which the solo line can be played or sung. How is this achieved? When I wish to accompany the client’s music, I use their key (if there is one), tempo, timbre and dynamic, and I change these elements as the client does. If the client is playing a melodic solo line, I don’t use much melody, and likewise if they are playing a drum solo, I try not to be too rhythmic. This is because I am in a supporting role, and I am not trying make our musical connection too overt as it is already present.

Wigram says “*Accompanying: Providing a rhythmic, harmonic or melodic accompaniment to the client’s music that lies dynamically underneath the client’s music, giving them the role as a soloist.*” He continues “I often recommend its use when one has established a framework for clients to use or where the client is particularly autonomous and wants to take a soloist’s role in the music making.” (Wigram 2004: 106)

I feel that M is displaying autonomy and that his singing is a solo line. My accompaniment provides a pulse, a key, has a sense of harmonic progression and har-

monic tempo. Even though I am playing a lot, there is none of the busyness in the music that there was in the first extract when I was also playing quite a lot.

EXTRACT 8

So with M, I started out by matching, then using a pulse to organise his playing, then using silence and not worrying about tempo or tonality, and finally, when I felt we were really listening to each other, I could step back and accompany his singing.

To conclude I would like to say that if I had not had these ideas and ways of playing available to me in my thinking and playing, then I do not feel that M, or any of the clients I have shown you today, would have benefited from Music Therapy as much as they could have. But because I did have these options open to me, I was able to step back enough to think about what I could do, and how best I could use my music for their benefit.

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CHAPTER 39

*Present situation of music therapy in
the republic of Latvia*

Paipare, Mirzda

Poster Presentation

The five headlines-traditions, needs, hopes, first step and support of society

will introduce you with the history of music and music education in Latvia.

It is a rich heritage, which promotes the development of music therapy as a new profession in Latvia.

The urgent need of this therapy in Latvia is obvious due to the insufficient therapeutical supply for handicapped, ill and disabled people.

The first step, that has to be taken during the next five years, is to develop music therapy, and it might encourage other European countries which have not got this approach yet.

TRADITIONS: LATVIA – A SINGING COUNTRY

Latvia is commonly known as a country of

“singing revolution”

which was a form of non - violent civil resistance during the last years of occupation.

BUT IN FACT, THE LATVIANS HAVE GOT LARGE HERITAGE OF MUSIC AND SINGING TRADITIONS, WHICH IS STILL ALIVE.

It is proved in our every day life; in the existence of hundreds of choirs, and in holding song and dance festivals in Riga every four summers.

Latvians have always believed in *stimulating, protecting*

and *healing power* of music, it might be considered as a strong base of the development of music therapy.

NEEDS: LATVIA - AT THE PERIOD OF CHANGES

Latvia, like other European countries, has to cope with a long history of political changes, which has deeply influenced people lives and still does. As it is in every society, Latvia has to pay more attention to

- medical,
- psychological,
- social health problems in our society .

We have to support handicapped members of society in all possible ways and to promote the ways of their rehabilitation and health care.

Especially in the area of pediatrics, rehabilitation is just at the start of its development.

HOPES: THE HERITAGE OF LATVIAN MUSIC FOR MUSIC THERAPY IN LATVIA

As Latvia has got a huge heritage of its own music traditions, we can use it in the development of music therapy. This heritage includes singing and music instrument playing.

As we have got a large social experience from the heritage, we can use it, as a scientific and practical method in music therapy.

WE HOPE, THAT MUSIC THERAPY METHODS WILL HELP US IN OUR WORK WITH HANDICAPPED PEOPLE. THEY GO THROUGH THIS PROCESS OF REHABILITATION WITH PLAYING INSTRUMENTS AND SINGING.

THE FIRST STEPS: MUSIC THERAPY IS UP TO START

Liepja is a sea-port town, located at the west coast of Latvia on the Baltic Sea. Liepja is one of the towns in Latvia with the longest history in music education. There you can find Academy of Pedagogy, where teachers are trained for primary and secondary schools, and there is also a training program for teachers to work with children with special needs. In 1998 Prof. Dr. med. Werner Andler from the Children Hospital Datteln in Germany HELPED TO START and develop music therapy study program in Liepja.

In 2002 the first students started their studies in the licenced POST-GRADUATE music therapy PROGRAM. THE director of Music therapy study PROGRAM IS Mirdza Paipare.

SUPPORT OF SOCIETY: FOUNDATION OF MUSIC THERAPY IN LATVIA

Fondation Of Music Therapy (FMT) in Latvia was established IN 2000.

- **AIMS OF FMT:**

- to support music therapy AS A multisided kinds of therapy, to facilitate health care and integration possibilities for children and adults with special needs in Latvia;

- to inform society, pedagogues, parents, social and medical workers about music therapy AS A new medical technology and about its possible achievements in Latvia;

- to establish music therapy laboratories and placements for practice;

To procure the specific necessary MUSIC THERAPY equipment AND music INSTRUMENTS.

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CHAPTER 40

*The emotional and therapeutic value
of the music by the Music Therapy*

*Integrated Model –
MIM*

Perilli, Gabriella Giordanella

INTRODUCTION

The present paper concerns the intervention of music therapy according to the Music Therapy Integrated Model -MIM, elaborated by Dr. Gabriella Giordanella Perilli.

Since almost 15 years, MIM has been used with various pathologies, from serious neurological problems to psychiatric disorders, with different adaptations, but with repeated results of effectiveness and efficiency. (Giordanella Perilli, 1987; 1991;).

MODEL RATIONALE

MIM is an evidence based Music Therapy Interpersonal Model of dynamic intervention based on the following rationale:

1. Cognitive Sciences of second generation that consider human being as a complex system. Every human being may be considered as a whole, complex, open, and coherent meaning organization in dynamic change process, while interacting with his/her environment;
2. the research related to the temporal organization necessary to structure cognitive processes in human subjects with and without psychiatric disorders (Giordanella Perilli, 1995). Human beings organize their internal and external experiences through temporal organization which relies upon embodied image or schema. It is my opinion that there could be a linkage between human chronobiology, neurophysiologically based, and cognitive processes, since individual would develop their own schema of time, or subjective time and tempo, to be in tune and to interact with their physical, psychological, and social environment. Subjective Tempo is defined as own personal timing or pacing, with regard to psychomotor, cognitive, and emotional processes, or it is the speed at which a person can apprehend, register, and understand incoming stimuli. Externally, subjective tempo is the speed at which a person can react, plan, and implement a behavioural response to stimuli;
3. fundamental importance of the metaphoric process for the development of the knowledge (Johnson, 1987), based upon embodied imaginative schemata. Sound and Music are basic components of earlier life experiences and contribute to form at least three imaginative schemata concerning balance, movement, and rhythm, necessary to organize self-perception, as parts of a common over-riding schema, the schema of change which is the foundation of every biological and therapeutic process as well as of the relative metaphors (Giordanella

Perilli, 2002, 439-440), Embodied imaginative schemata provide models to organize human experiences with motor and perceptual components. They form the base of metaphoric process to acquire knowledge. Metaphor is an imaginative structure based upon human body interacting with its environment.

4. nonverbal knowledge as the first self-organized system to process information (e.g. music), and to give meaning to own experience;
5. needs and potentialities of human being;
6. attention is considered a complex cognitive function, the fundamental golden gate to be present and become aware of his/her own experiences aimed at a therapeutic change.
7. 7) attuning and entrainment as basic phenomenon also for human experiences.

METHODOLOGY

The methodology of the intervention considers four stages: contact, stabilization, problem-solving and reconstruction. (Giordanella Perilli, 1991). The methods and techniques are planned for cognitive, emotional, personal, and interpersonal areas, each with its own clinical goals, concerning function rehabilitation and personal development. Active and receptive techniques are created and adapted to every stage of the therapeutic process, and to the sub-goals corresponding at each stage designed in respect to individual needs and resources. In particular, it is the present author's opinion (Giordanella Perilli, 1998, 349) that, by MIM, it could be possible:

1. to access and control affective and emotional experiences
2. to overcome resistance and to afford emotional events
3. to activate and develop neuro-psychic, motivational fields (attention, memory, etc.)
4. to modify and maintain mood
5. to structure or re-structure temporal dimension (Subjective Tempo, Time Perception and Evaluation)
6. to build up a therapeutic relationship based on temporal organization and attuning, considered meaningful component for attachment behaviour and for interpersonal communication
7. to re-structure cognitive processes and thinking modalities, regarding self and other people, through emotional, metaphoric, and imaginative experiences
8. to allow expanded, or non ordinary, consciousness states to explore inner

- 9. world, and to develop new creative adaptive alternatives for difficult situations
- 10. to develop a cooperative behaviour in social interaction
- 11. to motivate people to participate at his/her own therapeutic process and change.

STAGES AND GOALS

Each stage has its own goals, as follows:

Contact:

- to stimulate attention
- to allow personal and interpersonal communication
- to observe subjective tempo
- to allow instrument exploration

Stabilization

- to develop and stabilize cognitive process (attention, perception, memory)
- to develop and stabilize psychomotor abilities (space and body perception, motor coordination)
- to develop and stabilize personal boundaries, and to distinguish self and others
- to develop time perception
- to train in synchronization and entrainment
- to develop individual motivation
- to allow inner exploration

Problem Solving

- to develop communicative and social abilities
- to develop problem solving capacity
- to allow awareness and expression of own emotion
- to organize or re-organize subjective tempo

Reconstruction

- to modify irrational belief, to increase self esteem and social skill
- to develop abstract thinking and metacognitive modalities
- to develop intentionality and ability to consider consequence and responsibility
- to promote integration between sensation, emotion, thought, and behaviour
- to develop empathy and cooperation
- to develop creativity, and stimulate pleasure for novelty
- to develop or promote mental health to afford life difficulties, to increase self esteem, and well-being

To illustrate some issues of the above theory, a clinical example will follow., while some Case Studies will illustrated it with more details.

CLINICAL EXAMPLE

Loredana is a 33 years old woman, suffering for paranoid schizophrenia since she was 17 years old. During the last four years she has been living in a community for mental health. One day she comes to music therapy group session in a very bad moon: she feels angry against the whole world. In a first moment (contact), she proposes a song “Things I saw and that I would not like to see again”. After the listening experience, there is a verbal comment regarding the meaning of the song, stabilizing also the attention on her own emotion, associated to what she saw and that would not like to see again. Loredana tells the group that she felt angry and anxious when she was a teen-ager, since she believed that people had the willing to torture her. She goes on telling that also at the present people cause her pain and make her angry. Yesterday during the mass she would like to cry, but she could not since her mother dislikes this behaviour. So she felt blocked and angry against “cursed people”. By dialoguing, Loredana becomes aware of her negative thinking modality and takes her responsibility of her behaviour, telling that “ I feel moved when people take my hand and say: “The peace be along with you”. I understand that I cause my anger and anxiety since it is difficult for me to admit that people are very sympathetic and peaceful, but now I feel grateful toward people”. By this reconstruction, Loredana feels a deep joy which she expresses by singing “Havenu Shalom” to the group.

MUSIC THERAPY EXPERIENCES

Methods and Techniques are always implemented taking in account context, patient's actual needs and resources, and goals. They are grouped following the four stages, and with regard to neurophysiologic and cognitive, emotional, personal and interpersonal areas, or integration of all areas.

THE FOUR STAGES EXPERIENCES

TABLE 1. Contact

| Neurophysiological and cognitive | Emotional | Personal and interpersonal | Integration |
|--|----------------------------------|-----------------------------------|-------------------------|
| Subjective Tempo | Music chosen by each participant | Welcome and Greetings song | Music for special event |
| Response to different timbers, tonalities dynamics, rhythms, etc | | Self introducing song | |
| Free exploration of music material | | | |

TABLE 2. Stabilization

| Neurophysiological and cognitive | Emotional | Personal and interpersonal | Integration |
|--|---|---|------------------------------------|
| To memorize song | Sound-music improvisation to express emotion | Interpersonal Sound dialogue | Musical activities for celebration |
| To discriminate timbers, rhythmic patterns, tonalities, etc. | Polarities experience: to improvise on different emotions | To move, play, or sing along with music | |
| Rhythmic production and Re-production and time Perception | | Music from the world | |
| To Produce and reproduce Theme and variations | | | |

TABLE 2. Stabilization

| | | | |
|--|--|--|--|
| Polarities experience: Instruments or musical components | | | |
| To synchronize to music | | | |

TABLE 3. Problem Solving

| Neurophysiological and cognitive | Emotional | Personal and Interpersonal | Integration |
|--|--|---|--|
| To understand symbolic and literary song meaning | Association between song or music and personal emotion | Musical games | Musical activities for celebration |
| To learn unusual movement fol- lowing music | | To move, play, or sing along with music | Music Apperception Test - MAT |
| To do different actions with different sounds | | Polarities regarding self/ other characteristics | Combined Creative Experience by: - story telling while listening to music; - music improvisation/composition for relevant parts of that story; - story drawing, and - complete story performance. |
| To learn how to play new Instruments | | Personal life-story: - by improvisation - by pre-composed music/song | |
| Composing or re-producing song/music | | | |

TABLE 4. Re-construction

| Neurophysiological and cognitive | Emotional | Personal and interpersonal | Integration |
|----------------------------------|-----------|--|---|
| | | Music-song to support other person difficult situation | Music/song for change process and self development |
| | | | Dynamic Metaphors Improvisation Concerning early memories and their change |
| | | | Guided Imagery and Music |

FIGURE 1. Before and after a Group GIM session



FIGURE 2. Before and after a Group GIM session



CASE STUDIES

Some Case studies will illustrate the methodology. They regard patients who were followed for one year at an institute for disabled people with neuropsychological pathologies, and at a therapeutic-rehabilitative community for psychiatric patients. Modifications are evident in the various areas considered, comparing actual behaviours with those observed as base line, when we started music therapy intervention.

TABLE 5. Leonardo – Spastic tetraparalysis – 20 years old

| Area | Base line | After Music Therapy Intervention |
|----------------------------|--|---|
| Psychomotor behavior | Rigidity in his arms, hands and legs | Listening to repeated music, and rhythm: - he lifts his arms, arches his back, moves his head, increases his psychomotor responses - he opens his mouth and laughs aloud - he makes a sound like musical tone - he responds differently to: the same melody played with different instruments or in a different tonality and pitch; different songs played with the same instrument |
| Emotional | He smiles only to human voice, not to musical stimuli He reacts to tactile stimulus with a long latency | He smiles, laughs, trills, and vocalizes listening to song and music, except when he has health problems He shows music preference |
| Cognitive | He looks without a direction He does not react to new song (Welcome song) | He looks and turns his head toward music source He recognizes melodies (Welcome and Greetings songs), a preferred binary rhythm He distinguishes tonalities, timbers, and melodies |
| Personal and interpersonal | He is focused on his body functions | He looks at the singing music therapist and smiles her He answers music therapist's smile and voice, with smile and vocalization |

Among several musical activities and experiences, the following ones resulted particularly useful for the above modifications:

- To listen to songs and nursery rhymes 1) sung by voice alone, 2) played in G by the violin fourth cord, 3) sung to an instrument (violin, keyboard - organ timber)

- Tactile exploration of musical instruments
- To listen to binary, simple rhythms

Leonardo's preferences regarded:

- Human voice singing
- Lower timbers
- A rhythmic binary pattern formed by two quaver and threesemi-quaver with a semi-quaver rest.

TABLE 6. Manola – Down Syndrome – a 40 years old woman

| Area | Base line | After Music Therapy Intervention |
|---|---|--|
| <i>Psychomotor</i> | She moves only her pelvis to music Difficulty in moving her legs and feet, to lift her arms together, to move herself freely in space, and to follow instruction | By imitating a model she learns how to use space around herself, to move her legs and feet differently, and to clap her hands in a louder way |
| <i>Cognitive</i> | Serious difficulty to articulate and to memorize new words Her subjective tempo and time perception is extremely poor | She remembers and repeats new words, as instrument names Slight modification in ST and time perception |
| <i>Emotional</i> | She looks for physical contact with the music therapists Difficulty to speak aloud to the group “ <i>I feel ashamed</i> ”, and to express emotion | She sings her name and part of songs She express verbally some positive feelings (love, joy) |
| <i>Personal</i> <i>Interpersonal</i> | Low self esteem “ <i>I am unable</i> ” Difficulty to interact with the group | She chooses and proposes songs and activities |
| <i>Integration</i> | Difficulty to draw to music without a model or instruction | She show autonomy in drawing to music |

The following musical activities and experiences were the most representative for the above modifications:

- Welcome and greetings songs: to sing, first, and, second, to understand songs meaning
- Welcome and greetings songs associated to simple body movements (arms, feet, legs)
- Self introducing song to learn the participants' names
- To choose a song and to listen to with free or guided body movements
- To choose music instruments for following rhythmically a song
- Games to learn and recognize names and timbers of different instruments
- To draw listening to music

Manola's preferences include:

- To dance with a pelvis rotating movement
- To dance with the therapists
- To clap hands to music tempo
- To listen and sing all together an Italian Christmas song.

TABLE 7. Felix – development impairment – a teenager boy

| Area | Base line | After music therapy intervention |
|--------------------|---|--|
| <i>Psychomotor</i> | A slight motor coordination difficulty | He does movements according to song words: jumping, lifting arms, etc. |
| <i>Cognitive</i> | Attention and memory difficulty A slight cognitive impairment Excellent rhythmic attitude and high ability to play the battery He chooses only percussion instruments Poor time perception, disorganized subjective tempo | He concentrates for a longer period his attention on musical activities He memories better song words He categories using polarities (e.g. black and white) He explores different musical instruments A more accurate time perception, Rigid subjective tempo |

TABLE 7. Felix – development impairment – a teenager boy

| | | |
|------------------------------------|---|---|
| <i>Emotional</i> | <p>Calm, sensitive to musical stimuli</p> <p>He participates with pleasure</p> <p>but is a lazy boy</p> | <p>By listening to music he succeeds to express his emotions and moods</p> <p>He proposes some activities</p> <p>By music and drawing he expresses his emotions (fear, sadness, etc.)</p> |
| <i>Personal and inter-personal</i> | <p>He expresses a poor assertive behavior, but empathy and cooperation</p> | <p>He expresses his likes and musical preferences. By request, he chooses song, activity, etc.</p> |
| <i>Integration</i> | <p>Lack of metaphoric process</p> <p>Rigidity in thought and behavior</p> <p>Lack in metacognition</p> | <p>He invents “<i>the Indian story</i>” listening to a musical piece and represents it by appropriate musical instruments</p> |

Among several musical activities and experiences, the following ones resulted particularly useful for the above modifications:

- To move to music with association of verbal meaning and movement
- To play musical instruments chosen by himself or by the music therapists
- To listen quietly songs chosen by each participant
- To accompany songs with musical instrument, voice, body movement
- To invent a story to music
- To illustrate by drawing and improvisation emotion, event, people of a story
- Musical games to learn timber discrimination, rules and turns
- To listen to and comment on tape recording concerning participants’ vocal or instrumental production

Felix’ preferences concern:

- To improvise on rhythmic instruments
- To invent a story musically based

- To represent by a musical improvisation the content of a story.

TABLE 8. Rodrigo – Schizophrenic pathology – a 39 years old man

| Area | Base line | After Music Therapy Intervention |
|----------------------------|--|--|
| Psychomotor | Block and rigidity He does not move to music | He moves to music and dances as long as music lasts |
| Cognitive | Confused thoughts and delusions “ <i>you are my sister</i> ” instead of music therapist Time is perceived as infinite Disorganized subjective tempo Rhythmic rigidity He plays guitar for a very brief time Difficulty to maintain attention Difficulty to concentrate, to think, and memorize | He adapts his subjective tempo to external duration His ST is more organized and differentiated He recognizes the music therapists and calls them with their names He maintains attention and focus on activity He plays a complete musical piece by the guitar and, sometimes, sings with the group He listens to a song from the beginning to the end |
| Emotional | Difficulty to recognize and to express his own emotions Lack of empathy | Frequently he verbalizes emotions to musical experiences He feels pleased with himself |
| Personal and interpersonal | Lack in self care Difficulty to listen and to communicate with people, to accept other person’s request, to socialize and be in relationships with the group | He takes self care He gives attention to people He improvises together other people, accordingly He asks people to play together |
| Integration | Difficulty to recognize and verbalize his emotion, thought, recollection associated to a musical piece Difficulty to characterize sound stimuli, and to transfer them to a behavior (metaphoric projection) | He participates with proposal Self image as active Some modification but not permanent and meaningful change |

The following activities and experiences promoted, particularly, the above modifications:

- To listen to musical pieces chosen by himself or by other participants, to verbalize the meaning of the text, the evoked or associated emotions, images, and recollections

- Musical instrument exploration especially for timber quality
- Rhythmic reproduction either by his own body or instruments
- To verbalize experience
- To tell a story (individually or in group) to music

Rodrigo's preferences regard:

- Piano and violin – he begins to learn the piano
- Listening to classic guitar pieces
- Instrumental improvisation.

TABLE 9. Loredana – paranoid schizophrenia – a 35 years old woman

| Area | Base line | After Music Therapy Intervention |
|--------------|---|---|
| Psycho-motor | She refuses to get up e move to music She gets tired easily Poor arms and legs articulation | She dances and sings to music She moves by accompanying with her voice |
| Cognition | Paranoid thoughts toward outside people and music therapy participants (<i>damned people</i>) Concrete thought no abstract conception She knows many songs and sings them while listening to Poor instruments exploration Difficulty to maintain attention Poor time perception Not flexible subjective tempo | Reduction of paranoid thoughts (<i>sympathetic people</i>) She organizes and verbalizes her thoughts with fluency and coherence She concentrates her attention longer on activities and gives more attention to other people's activities Improvement in time perception More differentiation in ST |
| Emotional | Poor tolerance and patience to situation which require ability and responsibility Difficulty to express emotions Very anxious Her face has a gloomy look | She verbalizes easily her emotions More tolerant Less anxious Her face has often a smiling look |

TABLE 9. Loredana – paranoid schizophrenia – a 35 years old woman

| | | |
|----------------------------|---|--|
| Personal and interpersonal | Intolerant toward herself and other people She does not wait for her turn | She is more tolerant toward people and situations She waits almost for her turn |
| Integration | She does not relax and is unable to do imaginative experience Difficulty to characterize sound stimuli, and to transfer them to a behavior (metaphoric projection) | She relaxes and accomplishes guided imagery experience Able to use metaphorical thought |

The following activities and experiences promoted, particularly, the above modifications:

- Listening to musical pieces and discussion on meaning, emotion, musical characteristics and components, etc.
- Guided Imagery and Music
- Rhythm improvisation and re-production by instruments or different body parts
- Projective listening (e.g., to tell a story individually or in group).

Loredana prefers:

- To listen to songs
- To sing alone or together with the group
- To play along with other people – ensemble performance
- Listening to and commenting on tape recorded vocal and instrumental performance either executed alone or by the whole group.

DISCUSSION AND CONCLUSIONS

If we analyze the whole therapeutic process, we can observe how music therapy played a positive role from beginning to end, with individual differences as far as the developmental stage reached by each patient, with consideration of individual disturb and personal relationship with music. Nevertheless each participant was motivated to play an active role in his/her own process of change, overcoming his/her resistance to therapy and therapist. MIM intervention helped to integrate verbal and non verbal aspects of awareness, so that the different or new modalities of

understanding could be transferred outside the therapy session into patients' daily life. Change were observed and appreciated by other professional people, including neurologist, social worker, psychologist, and psychiatrist.

We found some exceptions concerning the treatment effect as far as:

- psychiatric patients with a double diagnosis (e.g. drug dependent and borderline personality). Working with those patients, at a first time our Model seemed to be efficient, but the results were absolutely temporary, like a honey moon effect;
- very severe psychotic adult people with a post traumatic stress disorder, and an autistic behaviour. Here again we observed a modification in their behaviour (e.g. more attention, a little interest in music activities, and a facilitation in social interaction). But they were unwilling to go on, so they stopped to come;
- some very severe neurological patients with whom we obtained very poor and unpredictable motor and attention responses.

As regard as Subjective Tempo and Time perception, we found some modifications not really outstanding with those patients. If we compare the treatment period with other interventions we did, it is clear that, for this aspect, it is necessary almost a three years period in order to modify subjective tempo organization in a more adaptive way. In fact subjective tempo and time perception are schema with neuro-physiological bases and, then, require longer experiences to be modified, in case it could be possible.

A text of the poem, composed including words told by each participant, can synthesize some meaningful change achieved by our psychiatric group who followed our music therapy intervention for one year. During the last session, each participant read his/her own words on a musical base. The poem was taped and given back to them, as a concrete proof of their change. At the end of that session, the whole group, including the two music therapists, was deeply moved. They patients told to other operators, the psychiatrist, psychologists, and social worker, that only by music therapy they discovered their emotions, could express them, understand their thinking modalities and change not functional way of thinking. They really trusted in themselves, since they discovered that, notwithstanding their psychiatric disturbs, they have resources like normal people to take care of their own life, with some help from others. They told that "music amplifies our soul and our mind. It allows us to explore our spirit and moves us deeply".

FIGURE 3. Music Inside

Lost within emotions, I find myself in songs,
Together we break fear and human egoism.
By music we discover inside our courage,
To go out from this grief.
Bewilderment lived here, in the world of unusual people,
Scratches me inside but with music I feel a change.
I feel pain in songs, too,
Person outside is not without fear.
He feels discomfort and anger, disappointment and sadness.
But music fellow, the life core,
Recreates his harmony, and brings me:
freedom wind
vital water
internal quiet.
Music goes into myself gently and cheers me.
Like the storm beats the horizon and then finds the calm,
While the rainbow is rising very slowly.
The music gives me messages of infinite variety:
It helps me to understand emotions,
It helps me to discover in my mind
New ways to stay with people,
Whom I feel sympathetic and solid
For holding out their hands to help me
To build up a serene life,
A Good morning for a better world
By a song filled by love.

FIGURE 4. “By music experience I was curious to explore inside and outside world. Now I am aware that there is earth, sky, and below, as in myself, too”



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CHAPTER 41

“LIETE DISSONANZE” (*happy
dissonances*)

Pizziolo, Paolo & Corti, Nicola

**A digital audio recording experience in
a songwriting music therapy
intervention with psychiatric adult
clients. An application of new
technologies in the therapeutic process**

Editors note: Check for the html version with all video and audio files on
MusicTherapyToday.com (November 2005)

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Abstract

Liete Dissonanze is the concrete result (an audio CD) of two years music therapy intervention based upon a creative process regarding songwriting, putting the songs to music and recording them.

The focus of this work is to present how the songs were recorded: by using low cost digital audio technologies we were able to increase and develop the goals of our music therapy intervention.

introduction

The CD is a finishing point and yet a new starting point in the music therapy activity:

- A finishing point because the song production work is completed, and also because the cd was ready in time for a public presentation in a local theatre during Christmas festivities which brought the work to public eye.
- A new starting point because new musical and artistic elements emerged during the recording session. They were further developed through new work modalities in music therapy.

OVERALL DESCRIPTION OF THE MUSIC THERAPY INTERVENTION

This music therapy intervention consists of songwriting composition using lyrics or text material produced by the clients themselves. In this intervention creative participation and self-regulation have defined the song writing composition layers (diverse and sometimes operating simultaneously)

- lyrics writing: developing in strophic form or words suitable for music form
- musical choices: group or individual choice of the form /style suitable to their lyrics,

- a kind of *monitor-evaluation* of the creative process which evolved to a self-monitoring/testing of all participants (Pizziolo, 2003)

A common feature of the song composition layers and the evaluation activity is to encourage and facilitate active choices by the clients

THE CONTEXT

Our music therapy intervention was held in a day centre of psychiatric rehabilitation dedicated to the rehabilitation of medium to severe cases of mental disorder. In general, disturbances in these particular patients are personality disorders, like schizophrenia.

The non pharmacological rehabilitation activities provided by the centre are mostly group activities and their common feature is to be matching spaces for reality world and “inner” worlds of the clients. Beyond the material aspect of the activity (such as cooking, painting, clay modeling, daily outings, group trips holidays and conversation) different emotions are activated, so by becoming aware of them these emotions are easier to handle.

Music therapy was carried out with 15 clients from 30 to 65 years of age.

This weekly intervention began in 2001 and is still going on.

Music therapy started as an extension of a previously existing singing activity. The target of the intervention was to accompany patients while singing with the purpose of socialization.

The song writing activity began because three patients wrote lyrics themselves and asked us to put their words to music. We decided to follow this specific need of the clients. After about five months every patient had handed in at least one text which was set to music.

SONG WRITING

The text can also be re-elaborated in the music therapy session:

Working with the text in the MT session means developing the text with the consent of the author (therefore create unity / togetherness among the group) but without changing the style unless requested. This gives value to the creative characteristic of the client. The most frequently developing features are adding or inserting phrases and finding synonymous expression.

The most common cases of text presentation:

1. Patient gives a text already structured in a metric form or written in a narrative - discursive way. The work is then to transform the text into verses through a discussion with the music therapists and the rest of the group.
2. We write a song together with the group of patients, trying to transform an oral narration into rhyming verses.

The two forms are characterized by an active choice and selfregulating positive interaction concerning the text element of the song, the theme, the words to describe it, plus the author's right of veto in relation to the proposals and suggestions by the music therapist and the group. The text takes form in a feedback between the client's inner dimension, from which the text is born, and the sharing of it by the group.

THE AIDED MUSIC COMPOSITION PROCESS. We have tried to classify the different ways of composing songs together by the group using the criteria of observing how the music therapists, the group, the author of the texts, were active in proposing some song ingredients (like melody rhythm, style and some text elements, such as “lyrics pre-working”, metric and strophic structure)

In most cases the process began by the music therapists providing a list of different music styles such as playing the guitar, singing or both.

The different styles are featured by the rhythmic accompaniment on the guitar and the chords sequence.

The list allows a patient to choose the music style for his words, similar to the choice between two or three playing cards from a full deck. They are pre-chosen by the music therapists in accordance to the patient's age, his or her known likes and dislikes and his/her varying moods. This proposal is the basis on which one can begin to improvise the melody line and the text partitioning

THE AIDED COMPOSITION MODALITY: . Here is a summary of the five composition modalities:

- composition modality 1

the client presents his own text , just chooses one of the styles and makes no further contribution.

- composition modality 2

the client present his own text. The client is active in choosing one of the styles BUT brings his own rhythmic idea The group work influences the rhythm and the type of style, the text partitioning.

- composition modality 3

The client presents his own text, is active in the choice of style. He brings his own melodic ideas.

The group-work influences all the other aspect of the composition activity.

- composition modality 4

The text writing takes place during the first part of the session while the musical options are put forward by the group (style and rhythm) or by the music therapists (melodic).

- composition modality 5

Collective group work involving all the compositional aspects ... without previous work on the text.

The author has the right to veto as regards all these elements in relation to proposal or suggestion put forward by the music therapists or group.

Also in this case we have an example of creative feedback between the author/group.

A feeling of sharing and trust between the group members including the staff and the therapists is formed and this is shown by the many songs produced by the group.

During some music therapy session of assisted composition also the song arrangement modality is often defined collectively. Professional musical instruments and percussion are used.

A FURTHER STEP : RECORDING THE AUDIO COMPACT DISK

The CD was made in a short space of time (3 months).

FIRST KIND OF RECORDING

Our first idea was to record the songs in the way they were usually sung by the group: a chorus accompanied by guitar and percussion, a kind of live recording.

We used a digital audio recorder, a Mini disk. Together with the group we listened to the recording immediately afterwards. The clients were not really happy with the result:

- too much reverb due to the high ceilings of the public buildings
- in the recordings voices could be heard singing out of tune more so than in a live performance
- individually the clients' reaction to hearing their own voices recorded was not always positive: they didn't like the timbre

In general we can say that this kind of recording does not give a positive feedback to our clients.

AUDIBILITY

This was a critical step because we had to face the problem of insufficient *audibility* of the sound material we recorded. The song serves the client as a social-emotional interface between himself and his environment. It is very important that the client receives a good emotional feedback through the song and its hard copy (the recording) when presenting it or making other people listen to it.

According to us one of the many task of the music therapist is to take care of the achievement of a dignified audibility by allowing the artistic features of the sound material to emerge (for example emphasizing the strength of the text through particular quality of the voice)

We can make a comparison between the works of the neo-realism film makers (Pasolini, De Sica) when they used cine-camera to bring out particular and spontaneous physical and expressive aspects of nonprofessional actors. These actors were often socially rejected people, and showing their work gave them a measure of artistic dignity.

The research of this **audibility** gives clients a presentable audio material coming from their own expressive feature.

Normally these expressive features are just experienced as problems correlated to social disadvantage due to the psychiatric disturbance.

It is important to help the client recognize his own peculiarity **also as a point of strength**.

Therefore we decided to record in a more professional way using two multi track recording software, one of them dedicated to the handling of audio samples. This kind of choice is to be read as an expedient to face the **audibility challenge**.

RECORDING DEVICES :

laptop pc – audio digital interface USB – computer box (20 wat) – 1 mic Shure SM 58 - syntrillum Cooledit PRO ACID 4.0 (software).

SECOND KIND OF RECORDING

We had to use various solutions to revalue audio-vocal material which had been recorded but did not sound usable, giving it a new dignity to be listened to.

By using low cost digital audio technologies we were able to increase and develop the aims of our music therapy intervention: Re-vitalize the client by

1. Facilitating active choices,
2. Creating a meeting point between the inner world of the client and the outside reality (either with the therapy group and/or their social environment such as their relatives)

The recording and mixing session has increased the clients' possibilities to make active choices in the creative process about many musical features (usage of voice tracks, usage of audio samples, song structure)

The *Harlequin Voice* is one of the many expedients used to find solutions to emerging problems during recording and mixing sessions.

What we call the *Harlequin Voice* is a Cut and Paste technique on the audio tracks, sewing together audio fragments and giving a new dress to the song.

Other expedients used are listed below:

1. usage of concrete sounds (domestic utensils, whistling, blowing on plastic medicine bottle)
2. voice reading poetry

3. the way of mixing the voices together

Thanks to these expedients unplanned solutions came out in a creative process in which the clients were involved.

Some of these elements will be presented in detail in describing how some of the songs were recorded.

THE SONGS

- SONG 1 : Prendo il treno (taking the Train)

It involves the harlequin voice. It consists in creating a melodic line by using small melodic fragments taken from different audio tracks sung by different singers. It has been realized on the song *Prendo il Treno (I Take The Train)*.

The first idea was to re-create the choir effect by mixing together many different vocal takes.

So at the beginning we recorded a leading voice and guitar track and the clients have recorded their voice listening to this background.

During the mixing session we were unable to recreate the virtual choir because we could not count on the masking effect: many recorded tracks were mostly out of tune as it was one of the first times the clients had sung individually in front of a microphone, wearing a headphone, and listening to vocal guideline while singing. It is possible that these circumstances did not help the client to stay in tune.

After a discussion and in agreement with the clients it was decided to construct a melody, using the cut and paste method from the few fragments in tune performed by the patient who had written the song. We were lucky because the song was written by many clients together and so we were able to represent them using many different fragments.

We could say it is a sound representation of an aware group made up of different voices.

FIGURE 1. Liete Dissonanze 2002: Public Presentation Of The Songs



The live performance of this song is still in choir form but we have an echo of the harlequine-voice technique in two small melody fragments sung in a soloist form by two clients who asked to sing their intervention as it is on the CD.

FIGURE 2. LIETE DISSONANZE 2004: ONE OF THE PUBLIC PRESENTATIONS OF THE CD



FIGURE 3. LIETE DISSONANZE 2004: ONE OF THE PUBLIC PRESENTATIONS OF THE CD



The harlequine voice might have been achieved from other pieces as well but this was not possible due to lack of time,

Taking the train is an example of the involvement of clients in the choice of rhythmic and bass samples to use in the arrangement of the song: this is a chance to take an **active choice** together with the rest of the group in creating the final product. The “techno” style of this song was decided by the client.

Other audio fragments were used like sounds of trains taken from *Etude aux Chemins de Fer* by Pierre Schaffer (1948) and a little whistle sound made by blowing into a plastic pill container.

LISTEN TO SOME AUDIO INGREDIENTS:

pill whistle [insert pill whistle.mp3],

bass loop [insert bass.mp3],

drum loop1 [insert drum.mp3],

drum loop 2 [insert drum2.mp3],

Schaffer train [insert train.mp3]

So many different sounds and maybe some considered without specific musical value have taken form in an **audible**, structured musical piece.

This can represent a sound metaphor of the psychotherapeutic treatment in which the core of the rehabilitation is the recomposition of a broken inner unity. This broken unity in the individual is correlated to the various kinds of a client's mental suffering.

[insert taking the train.mp3] extract of *takin the train*

SONG 2 : Cara Mamma – Dear Mummy (GIUSEPPE: 30 YEARS OLD)

In general the text of these songs are autobiographic flashes (in this particular case the song refers to Giuseppe's life when he was abandoned by his mother). For this song we have used the voices of a client, of a music therapist, and of a caregiver member of the staff. The song has a rock arrangement for better *audibility* but also to be better appreciated by the group. In fact Giuseppe (30 years old) was often derided by the other clients because of his musical preferences generally oriented towards *retro* songs as melodic songs of the fifties, tangos or *beguine* style. In order to cope with this situation we built up a pop arrangement for the text and the melodic intonation proposed by Giuseppe. In this way the sound material of Giuseppe was revalued and appreciated by the younger clients of the group who generally prefer pop and rock.

The individual therapeutic spin-off . The mix of Giuseppe's voice within a modern arrangement close to musical preferences of the group led to the realisation of a product shared by the other clients. Furthermore it was a good opportunity for Giuseppe to communicate something about himself and to be recognised by the group for his particular personal experience. The therapeutic methodology was useful for the client to strengthen his belonging to the group. The idea of belonging was a stimulus to change his capability of social adaptation through increased attention to the other clients, and less egocentrism and susceptibility to jokes. This song was deeply metabolised by the whole group who performs it also in live presentations. Also for this song we would have used a harlequin voice if we had had enough time.

listen to a *Cara Mamma* extract

[insert Dear Mummy.mp3]

SONG 3: NO PENTAGRAM (VIERI 52 YEARS OLD)

In this case the author was not able to sing his song in tune. The musical expedient adopted was focused on bringing out Vieri's voice through the building up of a special track of talking voice instead of a singing melody. In this way the music track was sung by the group acting as a melodic echo. It was like a sound representation of the psychological group support to the single client.

THE INDIVIDUAL THERAPEUTIC SPIN-OFF . The experience of the recording of his song and the fundamental support provided by the group to Vieri gave him a new self confidence. In particular he threw off some of his shyness and his tendency to hide from others. During live presentations he was able to perform alone, reading his text in front of the audience.

Listen to a *Nessun pentagramma* extract [insert : No Pentagon.mp3]

CONCLUSIONS

We wish to point out some therapeutic characteristics which came to light during the recording of many songs:

SHARING SOLIDARITY

During the individual recordings of the voice tracks the group is capable of perfect silence. The recording session becomes a moment also to share the tension due to the re-listening of the completed individual recording. This feeling of solidarity among the group is manifest during the live performances.

MUSICIAN DIMENSION

The computer is a status symbol because it is a professional tool for musical activities. The clients, through the use of this tool, have a feeling of being in the same dimension as professional musicians. In our culture music is related to the technological and media devices: CD, radio, hi fi, etc., thus the use of computer for musical production gives the clients the idea of participation in the real world of music and therefore of belonging to a social and cultural dimension.

AUTOBIOGRAPHIC FLASHES

The songs are autobiographic flashes and allow the clients to free themselves through communication. By telling their own story, their past history is transposed on different levels and can be re-elaborated from a new perspective.

PROTHESIC VALUE

The CD has a prothetic value because of its “telling” positive value and because it is a lasting product; in a way it can enlarge a client’s self esteem. It lives on and is always there for future reference.

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CHAPTER 42

The use of the guitar in clinical improvisation

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Editors note: Check for the html version with all video and audio files on Music-TherapyToday.com (August 2004)

Introduction

When I was studying composition and I enthusiastically undertook my studies of the historic avant-garde of contemporary music, I looked with curiosity and fascination at the world of rock music, where the guitar is the main instrument, so alien and unaware compared with the deliberation of musical language which characterizes the world of academic composition.

A music therapist could easily find himself in situations where knowledge of the guitar is required. Many times I have found myself having to answer one of the classic questions from people who are interested in learning more about music therapy, that is: “does a patient who comes for music therapy have to know how to play?” Clearly, my answer is: “No, it’s not at all necessary to be a musician in

order to be a music therapy patient”. However, I have to say that in clinical practice, especially in the area of palliative care and in work with neurotic patients, I more and more often find myself dealing with people who have a certain technical ability in an instrument, and in particular, guitarists.

The guitar is a practical and portable instrument and it allows the music therapist to move freely in the setting and to be close to the patient especially when, as in the treatment of oncology patients, the situation specifically requires it. Moreover, the sound of the guitar allows an extremely close relationship with sound intensity, and it is therefore possible to control its dynamics right up to the threshold of silence. The guitar is therefore an instrument with strong cultural connotations. If this, from a certain point of view, is a positive element for understanding a patient’s musical world, at times it can also form an obstacle in the path which leads the patient towards free improvisation.

In this article I will present two clinical cases belonging to very different contexts in order to demonstrate that the guitar is a versatile instrument capable of offering a wide range of intervention possibilities.

The use of the guitar in treatment of a case of severe mental disability

The guitar is an effective instrument in the treatment of young people and children with severe retardation, psychosis or disability problems. Its characteristics can involve patients in the music and for this reason it can be a valid substitute for the piano. Furthermore, certain tricks, such as alternative tunings, can be used with the guitar which allow young people to avoid experiencing the frustration of being in contact with an instrument they don’t know. In particular, an open tuning, for example on the chord of G major, allows the patient to improvise and immediately obtain a result that, suitably structured by the therapist’s improvisation, immediately takes on musical significance.

Stefano is a boy of 17. The therapy started when he was 14 years old and lasted for three years. His diagnosis is not clear. After a series of genetic examinations, they have not been able to reach any definitive conclusion, even though he has clear psychotic traits. His language is very limited, bizarre and non-communicative. He is unhealthily attached to his mother and becomes distressed when she is absent. He tends to favour relationships with mainly soft objects which are invested with the maternal relationship, since the relationship with these objects cannot be threat-

ened, they can be manipulated and they can tenderly consent to satisfying his needs. He shows different types of stereotypy, such as flapping his hands and rocking, and vocal stereotypy, such as the repetitive production of the same sound forms, which appear in the form of babbling or small obsessively repeated melodic cells. Finding a straightforward pedagogic intervention to be restricted, the professional educators who took care of him suggested the possibility of music therapy treatment to his mother, which was Stefano's first therapeutic treatment apart from periodical meetings with a neuropsychiatrist. In the first few sessions it was very difficult to get Stefano to respect the limits of the setting. He tended to go out of the music therapy room often, looking for his mother. The temporary separation provoked fits of anger in which he often knocked over the instruments on the floor or threw them around the room. In the beginning, I tried to fit what happened in the context of the session into the frame provided by the improvisation, containing and organising the sounds that Stefano produced during the session according to the principles of a specific musical language. In this phase the treatment had as a reference point the avant-garde music of the 60s (such as, for example, *Mikrophonie I* by Karlheinz Stockhausen). From a formal point of view, the improvisation had the function of building musical structures starting from rhythmic and melodic cells that Stefano randomly and spontaneously produced. Using the piano and percussion, these sound events were developed using typical techniques of seriality, like Webern's *Spiegelbild*, and at times some typical forms of series treatment (Inversion, Retrograde) applied both at a micro-structural level (considering the rhythmic-melodic events as fragments of series) and at a macro-structural level, even applying the principle of symmetry to sound events far apart in time. This strategy was successful when Stefano realized that his sound production in the setting was part of a meaningful musical context. From that moment he started to accept and acknowledge my presence and reduce his aggressive behaviour during the sessions. Subsequently, the voice work started in which I tried to guide Stefano into varying his repetitive melodies with the aim of producing the first outline of a musical form.

The guitar was the first instrument that Stefano agreed to play, and this represented the first step towards our being able to play together. The other instruments in the room, such as the piano or percussion, did not arouse any interest in him, or were completely refused. With the guitar, a process began which led Stefano towards greater independence in his musical production as well as towards the initial development of his ability to shape the music. In the beginning, I used the guitar as a space between us in which the instrument facilitated the turn taking without the distance between the boy and me being experienced with excessive anxiety. The musical material consisted of simple songs whose text referred to what was happening in the relationship and in the setting. These songs might take their cue from a small

melodic cell produced by Stefano, or from the rhythmic variation that could be taken from a motor stereotypy or from the sounds he produced while he handled the objects. In the improvisation you will hear, the guitar was positioned between Stefano and me, resting on a small table. Stefano played the guitar tuned to G with the plectrum (this was the very first time Stefano had used an instrument to make music) while I changed the chords on the guitar fingerboard and sang a melody.

Stefano interrupted the music several times to seek physical contact, touching me or taking my hand to ask me to play.

Download Example1.mp3 (4,2MB)

Through these early experiences with the instruments, which lasted for several months, Stefano started to acquire a certain confidence in his capability to play an instrument, and his autonomy in the therapeutic context increased. These achievements had a positive effect on his relationship with his classmates. The time that Stefano spent sitting and rocking, or performing his stereotypies, was reduced significantly.

With the passing of time, Stefano started to improvise on the songs played during the sessions. At first he systematically repeated the same melodies, basically taken from children's songs that he knows well, adapting them to my accompaniment.

Download Example2.mp3 (2,3MB)

Little by little, his singing took on the features, although still in a fragmented way, of an improvisation that was more and more disconnected from the repetition of the usual patterns, and he began to use more personal musical invention and to make small variations which began to move towards the creation, although at an embryonic stage, of a new musical form.

Download Example3.mp3 (2,1MB)

The use of the guitar as an instrument for improvisation in palliative care

Part of my clinical work is dedicated to therapy with adult patients who have problems that can generally be placed in the area of neurosis and with oncology patients both at the terminal stage and in the phase of remission of the illness. We are talking

about very different areas of intervention, but in which we can identify a common denominator, free improvisation. Music is not simply a medium through which the relationship between therapist and patient is created. Free improvisation is the area where the personal dynamics of the patient are revealed and where some mental structures can be perceived which, following other paths, appear as symptoms or dreams, returning in any case to a common origin. For example, when a patient recounts a dream in a session or tells us about the suffering connected to the inevitable recurrence of a symptom, the same affective structure often recurs in the musical structure of the improvisation.

Free improvisation does not emerge from a plan. It is absolutely essential that the music of the improvisation be produced respecting the subject's discourse, without forcing the meaning into preset limits or codified literalisation.

The main instrument in this type of improvisation is the piano, but in some cases, for example in palliative care, the guitar takes on a fundamental role. It is a versatile instrument because it offers the possibility to work on all of the basic musical parameters. It is a perfect instrument because of the possibility of obtaining subtle dynamic shades, which is of great importance in situations where willingness to listen and receptiveness to the other person's silence become particularly important elements. In the area of psycho-oncology, the general structure of the improvisation is obviously different to that used with neurotic patients. In this case, the intervention starts off from a mental condition which at times borders on all-absorbing anguish. Particular care must be taken of the emergence of trauma, which in these cases happens without any symbolic mediation. Here, the music therapy intervention can create the conditions for a process which helps the patient live his last days attempting to connect to the sense of his personal story, to the memories and emotions of an entire life, in other words, of the already lived.

However, it is also possible that, at the same time, the anguish associated with the illness catalyses a further process which brings the subject as close as possible to individual development. In this process, the verbal part mainly takes on the role of processing the experience connected to the musical one, touching delicately upon the themes related to suffering.

I would like to let you hear some extracts from the improvisations with a young terminally ill patient. With this boy the work was characterised by the use of different ways of using improvisation. In the first piece I'd like to let you hear, the patient plays a small lyre while I use the guitar. Technically, I tried to fit the patient's proposals into a musical form, developing the small melodic lines that instinctively emerged. The small lyre played by the patient was tuned to a modal scale and he

held it close to himself, holding it in his left hand while plucking it with his right. The musical dialogue that emerged in this improvisation is interesting both from the point of view of the musical development, but also because of the positive effect it had in bringing the patient out of his silence.

As well as developing and varying the patient's musical material, I tried to accompany him with the guitar in such a way as to support him in the moments when his suffering emerged more clearly. As you will hear, the dynamics in the improvisation vary and are alternated with moments of silence. The whole improvisation is characterised by these light intensities. The lyre is in itself an instrument with a rather moderate sound intensity. In work with oncology patients it is particularly useful because, by holding it beside himself, the patient receives positive feedback from the direct contact with the instrument. In this context, the guitar was able to communicate with this instrument, respecting its characteristics and allowing a dynamic control unthinkable of (difficult to achieve) with other harmonic instruments such as, for example, the piano. In the music of this improvisation we can hear moments in which the structure of the musical dialogue had the purpose of building the relationship with the therapist.

[Download Example4.mp3 \(3,4MB\)](#)

In the next example we can hear an improvisation in which both the music therapist and the patient are playing the guitar. Therapist and patient are involved in a dialogue that is more like a jam session. Here the patient has gone back to freely living his own musical identity and 'plays' with the therapist, suggesting ideas and harmonic sequences taken from his own musical history. The music therapist accepts the musical proposals, trying to facilitate the patient's musical expression as much as possible.

[Download Example5.mp3 \(3,2MB\)](#)

It sometimes happens that traces of these improvisations remain imprinted in the memories of the family members who took part in the tragedy of their relative. The recordings of the improvisations thus become a testimony of the journey concluded by the person who has died, a sort of intimate diary which continues to spread its poetic force beyond the time limits that the illness has imposed. The sound of the guitar manages to be close to those who have painfully experienced such a complex event, which cannot be reduced to any consolatory simplification. For someone who has lost a loved one, listening to the music of these improvisations again means being able to relive their experience in perspective, recalling, as well as the music, the most simple actions from everyday life which filled the last moments of

the patient's life. Underneath the sound of the guitars you can perceive the faint sound of dishes coming from the kitchen, the sound of the curtains closing, bird-song coming from the garden, the distant voices of relatives and friends trying to keep hope alive. The music recorded during the sessions keeps his vividness intact and represents an artistic will, a gift which has an enormous affective value for the family of the patient.

The cases that I have presented refer to situations in which the use of a specific musical language was appropriate. It is also from this point that we should start to read and analyse the musical material, taking into account the fact that certain musical elements, such as repetition and the use of tonal (and sometimes modal) language, are elements that are normally used in rock music and in children's songs. There are, on the other hand, cases in which the guitar can be played outside of tonality and using other timbric possibilities, such as "tapping" on the neck of an acoustic guitar, the use of the body as percussion and harmonic sounds.

I am convinced that the guitar is an indispensable instrument in music therapy and that its role is not secondary for those who use improvisation in their clinical work. The spontaneity that typifies improvisation on the guitar can be of great importance in the training of a student and he must be familiar with the most common guitar styles and techniques. I believe it to be very important to pay increasing attention to the study of this instrument applied to improvisation in the music therapy training courses.

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CHAPTER 43

*Theoretical and clinical approaches
for the treatment of traumatic*

*memories in music
therapy based
drugrehabilitation*

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Abstract

This article is about using the traumapsychotherapy approaches in music therapy based drugrehabilitation. Clients with drug addiction have quite often traumatic experiences in their past (all kind of violence, rapes, bad trips etc.) and they will get in touch with those memories during therapy process. As a music therapist I feel that it is good to be familiar with some theoretical and clinical traumapsychotherapy approaches which will make the treatment of traumatic memories more safer. The concepts of somatic memory, the modulation model, body awareness and the use of anchors will be presented among some others (Ogden, 2003; Rothschild, 2003).

Introduction

Drug addiction is a complex phenomenon. In my previous research and in my clinical music therapy work I have seen that clients will get in touch with their traumatic history during therapy process (Punkanen, 2004). Therefore it is very important to know how to work with those memories so that client's don't get retraumatized by them.

The method of treatment that I mostly use in drugrehabilitation consists of three different elements: The physioacoustic method combined with listening to music which was then followed by a therapeutic discussion. The combination of the physioacoustic method (low frequency sound therapy chair or mattress) and the listening to music provides the client with a very holistic experience that awakens both physical and mental sensations, thoughts, images and memories. The sharing of the experience with the therapist and the integration of treatment into the client's own life situation can open totally new perspectives and views of the addictive behaviour. (Punkanen, 2004.)

A client is most at risk for becoming overwhelmed or retraumatized when the therapy process accelerates faster than he/she can contain. This often happens when more memories are elicited into consciousness (images and thoughts from the music or body sensations from the physioacoustic method) than can be integrated at one time. (Rothschild, 2000.) By adding some traumapsychotherapy approaches into my clinical work I have found it to be more safer to me as a therapist and to my clients to work with traumatic memories.

The store of Traumatic Memories: Somatic memory

When we work with drug addicts who have traumatic background we have to understand how the traumatic memories affect to the person and how they different from other memories. In the late 1980s and early 1990s the idea of multiple memory systems became widely accepted. An important discovery during this time was two new types of memory, which are called explicit and implicit. Explicit memory which is sometimes called also declarative memory, is comprised of facts, concepts and ideas. It is explicit memory that enables us telling our life story, narrating events, putting experiences into words, constructing a chronology and extracting a meaning. (Rothschild 2000, 28-29.)

Explicit memory depends on language but implicit memory bypasses it. Explicit memory involves facts, descriptions, and operations that are based on thought. Implicit memory involves procedures and internal states that are automatic. It operates unconsciously, unless made conscious through a bridging to explicit memory that narrates or makes sense of the remembered operation, emotion, sensation, etc. Implicit memory is sometimes also called procedural or nondeclarative memory. (Rothschild 2000, 30.) What is meant by somatic memory? The implicit memory system is at the core of somatic memory. Drug addicts with traumatic history suffer inundation of images, sensations and behavioral impulses (implicit memory) disconnected from context, concepts and understanding (explicit memory). (Rothschild 2000, 37.) Traumatic memories lack verbal narrative and context. They are encoded in the form of vivid sensations and images. In their predominance of imagery and bodily sensation and in their absence of verbal narrative, traumatic memories resemble the memories of young children. Traumatized people relive the moment of trauma not only in their thoughts and dreams but also in their actions. (Herman 1997, 38-39.)

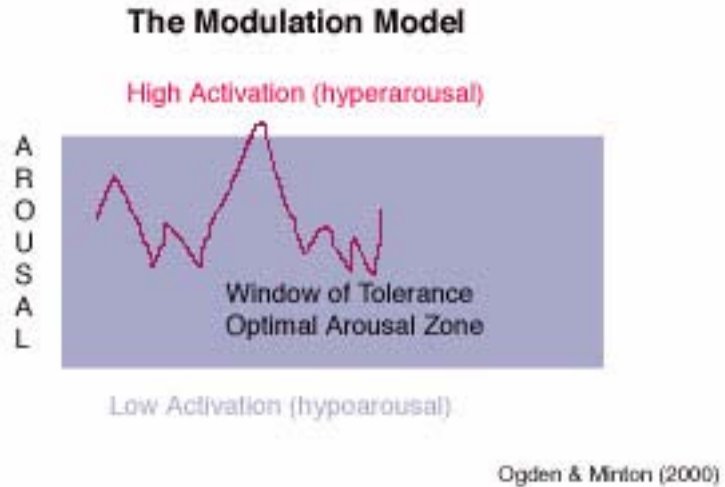
Traumatic memory is often re-experienced as fragmented sensory perceptions: images, smells, sounds, tastes, and bodily sensations, frequently accompanied by unregulated affect. Traumatized people “remember” the trauma as disjointed somatosensory experiences rather than as narrative account. (Van der Kolk, 1996.) It can be said that traumatic memories are stored in the body (somatic memory) and can be awoken with different sensory stimulus for example with physioacoustic method which sends low frequency sound waves to the client’s body. Listening to music is another way to get in touch with traumatic memories. (Punkanen, 2004.)

On Braking and Accelerating: How to help the Client to control the Traumatic Memories?

Rothschild (2000) compares the treatment of traumatic memories to driving a car. If we want to drive safely we have to learn the good combination of braking and accelerating. It is the same thing with traumatic memories. According to Rothschild (2000) it is inadvisable for a therapist to accelerate trauma processes in clients or for a client to accelerate toward his own trauma, until each first knows how to hit the brakes. We have to learn first how to slow down or stop the traumatic memories reliably, thoroughly, and confidently. (Rothschild 2000, 79.)

It is important to know how to bring the client back here and now, if he goes to the states of hyperarousal or hypoarousal which could happen easily during listening to music when images and memories start to awake. If the client is hyperaroused or hypoaroused it’s impossible to work with traumatic memories so that he/she could integrate them to the explicit, narrative memory. The state of arousal can be illustrate with the Modulation Model by Ogden & Minton (2000).

FIGURE 1. The Modulation Model by Ogden & Minton (2000)



If the client goes out of the window of tolerance which means the optimal arousal zone for the work with traumatic memories he will start to dissociate. That means that he is not here with us anymore. He feels that the traumatic event is happening right now and then we need to slow down the process and bring him back to the window of tolerance. (Ogden, 2003.) For that we can use different clinical methods.

Anchors

The concept of anchors has come to trauma therapies from neuro-linguistic programming (NLP). Basically, an anchor is a concrete, observable resource. It is preferable that an anchor be chosen from the client's life, so that the positive memories in both body and mind can be utilized. An anchor can be a person (grandmother), an animal (favorite pet), a place (home, a site in nature), an object (a tree, a boat, a stone), an activity (swimming, hiking, gardening), and of course music itself and music which reminds the client for the person, animal, place, object or activity which is important and meaningful. A good anchor is one that gives the client a feeling (in body and emotion) of relief and well-being. (Rothschild 2000, 93.) When working with drug-addicts with traumatic history it is useful in the beginning

of therapy process to establish at least one anchor to use as a braking tool anytime the therapy gets too rough. One good way to do that is to ask the client to bring with him a song or piece of music which include positive emotions and memories. Then you can establish the anchor by listening to that piece of music with client and guiding him to the positive emotions, memories and images of that music.

The established anchormusic can be applied quite easily during therapy session. When I noticed that my client's hyperarousal gets too high, I stop the process for a while and change the subject. I might ask the client to tell me about his/her anchor-music and memories connected to it. And at the same time I change the music for the anchormusic. The connection can be deepened by giving sensory cues that are associated to the anchor. One of the biggest difficulties of applying anchors is getting used to interrupting the client's memories and images during listening to music. However when it is clear how much inserting anchors helps the process, both therapist and client gain greater tolerance for such interruptions. Anchors helps you to keep clients in the window of tolerance and lower the base level of hyperarousal. After using an anchor you can guide your client back to his/her traumatic memories, but from a lower level of arousal than before the using of the anchor. According to Rothschild (2000) in this way, a traumatic memory can be fully addressed without the hyperarousal going out of control. (Rothschild 2000, 94.)

THE SAFE PLACE

The safe place is a specialized anchor, a current or remembered site of protection. It was first used in hypnosis for reducing the stress of working with traumatic memories. It is preferable for the safe place to be an actual, earthly location that the client has known in life. As such, there will be somatic resonance in the memory of it; sights, smells, sounds, piece of music, connected to that site will all be recorded as sensory memory traces, which will make it highly accessible and useful to the client. (Rothschild 2000, 95.) I always try to find a suitable music with the client for his safe place and very often client has it already. Quite often I also use slow, low frequencies (30-40 Hz) from the physioacoustic chair to help the client calm down and relax in his safe place image. The safe place image can be used during times of stress and anxiety, or as other anchors, to reduce hyperarousal during a therapy session (Rothschild 2000, 95).

Body/Somatic Awareness

What is body/somatic awareness? One definition is that “Body awareness implies the precise, subjective consciousness of body sensations arising from stimuli that originate both outside of and inside the body”(Rothschild 2000, 101).

According to Rothschild (2000) employing the client’s own awareness of the state of his body, his perception of the precise, coexisting sensations that arise from external and internal stimuli, is a most practical tool in the treatment of traumatic memories. Consciousness of current sensory stimuli is our primary link to the here and now; it is also a direct link to our emotions. Body awareness is not an emotion, such as “afraid”. Emotions are identified by a combination of distinct body sensations as shallow breathing + elevated heart rate + cold sweat = afraid. As a therapeutic tool, simple body awareness makes it possible to gauge, slow down, and halt traumatic hyperarousal, and to separate past from present. Moreover, body awareness is a first step toward interpreting somatic memory. (Rothschild 2000, 100-102.)

Some clients have a quite good sense into their bodies and will be able to describe their bodily sensations to others. However, quite often with drug addicts, when you ask, “What are you aware of in your body right now?”, they simply don’t know. They may be unable to feel their body sensations at all, or they may feel something but not have the words to describe their sensations. Others will have so little contact with their bodies that when they are asked that same question, they respond on a totally different topic. (Rothschild 2000, 102; Rothschild, 2003.)

There are several ways to help increase awareness of sensation: therapist’s observations about client’s bodily changes, establishing a vocabulary for sensation, asking accessing questions and the use of physioacoustic method and music as external stimuli.

THERAPIST’S OBSERVATIONS ABOUT CLIENT’S BODILY CHANGES

Therapists can help their clients to develop body awareness by observing the physical changes in client’s body: posture, gesture, facial expression, movements, self-touch, etc. The skill of observing both subtle and obvious shifts and changes as they are occurring in client’s body must be learned. Bodily changes can be as delicate as a slight skin color change, the dilation of the nostrils or the pupils, or a change in the pulse noticed in the artery in the neck. Or they can be as obvious as a collapse

through the whole spine, a full gesture with the arm, or a kick of the leg. (Ogden 2003, 10; Rothschild, 2003.)

According to Ogden (2003) an effective intervention that naturally follows the observing is making verbal contact with the observed changes. Simple statements, like, “I notice the collapse of your spine,” or, “Your breathing is getting deeper,” or, “You’re getting warmer” (indicated by skin color change), or, “There’s tension around your eyes right now,” direct the client’s awareness to his/her body. Such statements may seem rather simplistic, but they hold tremendous benefit in a therapy session, for they demonstrate to the client interest and curiosity in the body’s changes, and brings awareness to bodily sensations connected to the traumatic memories. (Ogden 2003, 10; Rothschild, 2003.)

INNER BODY SENSATION VOCABULARY

As musictherapists we are familiarized with a variety of words to describe different emotions like sad, angry, hurt, disappointed, irritated, fearful, depressed and so on. However, we are not so familiarized with a vocabulary that describes inner body sensations. According to Ogden (2003) when client is describing physical pain, he can simply say, “It hurts”, although there are many kinds of pain. Therapists can help clients refine and elaborate their description by providing a menu of sensation vocabulary. That will provide verbal options to choose from, and will spark clients own acuity for the language of inner body sensation. According to Ogden (2003) the following words are examples of sensation vocabulary: twitch, frozen, vibration, dull, airy, itchy, sharp, thick, intense, achy, tremble, mild, smooth, shivery, numb, jagged, chills, flaccid, and so on. (Ogden 2003, 10-11.)

ACCESSING QUESTIONS

Accessing questions are simply questions that require clients to sense their bodies and help clients focus in on their physical experience in the here and now. Accessing questions according to Ogden (2003) fall into the following categories:

1. General Questions: These questions are general, non-specific queries into sensation. They are useful at the beginning stages of exploration to help clients sense their bodies in a diffuse, undifferentiated way. *What do you feel in your body? Notice your inner body sensations. Where is the feeling in your body? What is your experience on the level of sensation?*
2. Specific accessing questions: Specific questions helps client to discover the details of sensation. Describing the exact particulars about the sensation helps fine-tune the awareness and language of sensation. *What are the qualities of that sensation? Where exactly do you feel it in your body? What are the parameters?*

Do you notice a central point to that sensation? Where does it begin and end? Does that sensation have a direction – does it go from inward to outward or outward to inward? What else do you notice about this sensation?

3. Comparison: Accessing questions that teach a client to compare various areas of the body may also help clients become more aware of their body sensations. (Ogden 2003, 11.)

THE USE OF THE PHYSIOACOUSTIC METHOD AND MUSIC AS EXTERNAL STIMULI

In my clinical work I use the physioacoustic method and music as external stimuli to awaken clients senses, images, emotions and memories. In my previous research I found out that the combination of the physioacoustic method and the listening to music awakened the participants' senses in a very holistic way from the first treatment session on (Punkanen, 2004). According to Caldwell (1996), when we treat addictions and talk about them, we often forget about the fact that our body with our senses is the most important part of the addiction behaviour. Withdrawing from our bodies is the beginning of addictive behaviour. (Caldwell 1996, 19-32.) With this Caldwell refers the neurologically proved fact that the bodily sensations function as awakers of our emotions (for example Damasio, 2000). Therefore when we become estranged from our bodily sensations we also become estranged from our emotions.

The combination of the physioacoustic method and the listening to music seemed in the light of my research and clinical work a very useful method to the drug addicts to get in touch with their own body and emotions and also with traumatic memories.

FIGURE 2. A client listening to music in the physioacoustic chair.



Conclusion

Drug addicts have often traumatic experiences in their history and we have to be aware of that when we begin therapy process. Physioacoustic method and listening to music will help our clients to get in touch with forgotten, unconscious, traumatic memories, which are stored through amygdala to the somatic memory system. Those memories are loaded with strong and painful emotions and therapist's have to have tools to make it safer to client's to face those memories.

Traumapsychotherapy techniques as anchors, safety place and body awareness can be easily added to the music therapy practice and it will give to our client's and to us as musictherapists more control to deal with traumatic memories.

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CHAPTER 44

Music therapy with demencia: a resource for reactivation

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This report will be divided into two branches: in the first one I will introduce an experimental work we carried out in the Sant'Eugenio Hospital in Rome, in the geriatric ward, concerning patients afflicted by dementia.

In the second one I will illustrate the continuation of this work, with a different methodology, carried out in the Diurnal Center of the Clinica Sacro Cuore, still in Rome, with some groups of patients afflicted by mild-moderate cognitive deterioration (in some cases with diagnosis of Alzheimer's Dementia) integrated into a

group of fragile elderly persons, at the risk of loss of autonomy, not afflicted by cognitive deterioration.

1st part theoretical scheme of reference and purposes of the research

This first part of the work concerns geriatric patients, afflicted by dementia.

The dementia, as many of you already know, (and I apologize for this repetition) is a syndrome due to a cerebral disfunction which is usually chronic and progressive with a trouble of many of the main cerebral functions such as memory, thought, orientation, comprehension, calculation and learning capabilities, language.

This syndrome has a very high incidence on elderly population. In Italy it has been surveyed a 6.4% prevalence of dementia cases on persons aged between 65 and 85.

The subjects contracting that all over again every year are almost 150.000.

Mostly, the memory, the long term memory but the short term memory first, the attention and the language are compromised; other depressive diseases are often associated to these symptoms and in some cases behavioural disorders, such as aggressiveness and psychomotor agitation, may also appear; progressively the capability of criticism, of abstraction and reasoning fail the subjects.

Sometimes it also can be found a damage to the capability of practicing actions, even though the motor capability, the sensor functions and the comprehension of the exercise are not compromised (apraxy)

The pharmacological treatment of this disease is more and more often supported by rehabilitative operations contributing towards the slowdown of its degeneration and reducing the symptoms.

On these bases, we decided to focus on a musictherapy intervention addressed to those persons afflicted by cognitive deterioration, in particular by the Alzheimer's dementia, that is the one with the most incidence level over the other forms of dementia.

The main target is to slowdown as much as possible the loss of the functions, by working on the still operating capabilities.

In this project, the intervention of musictherapy has been supported by the Reality Orientation Therapy (R.O.T.), a non-pharmacological approach to the forms of dementia, whose effectiveness, both on the cognitive and the behavioural side in the rehabilitation of patients afflicted by cognitive deterioration, has been demonstrated by several researches.

This operation concerns a small group of patients, with a mild or mild-moderate cognitive deterioration, without behavioural diseases. Its target is helping the patients to find again a relation with their own experiences, with the space-time dimension, and contributing indirectly to the improvement of the mood, the self-esteem and the socialization capability.

The musictherapy practical methodology has been developed by considering the particularity of the context and the typology of patients. It is based on a humanistic-existential model, integrated by cognitive-behavioural techniques.

The humanistic assumption allows a view based on bringing out the abilities: a human being, even though diseased by an invalidating and degenerative pathology, is a Person first than a patient.

Our approach considers Persons in their own entirety during the exercise, deprioritizing the pathology, bringing out their operating capabilities, their potentials, the most remarkable elements of their personal background, and giving them back an existential dimension. A person, considered as such, owns a huge quantity of human resources and inner richness which are helpful to start establishing a relation.

This relation built between the music therapist and a person, and the persons between them, allows to “refill” a distance that is more and more insuperable and deserted: the operation, carried out in an reassuring and empathic atmosphere, creates a sort of sense container where even the disjointedness of experience is welcome and returned changed.

The music therapist becomes a help for experience recall and grants an encouraging setting, organized in a steady way in order to ensure a predictability and a sense of confidence that favour the re-orientation. In this activity, the initiatives suggested by the participant are welcome, not judged, and are led, by using cognitive-behavioural techniques, towards a process of training where personal experiences and abilities may reemerge, and, by using a non-verbal mean, a mnemonic trace may be re-drawn, in order to strengthen an identity which is going to disappear progressively.

The cognitive-behavioural techniques of stimulation, by questions, recalls, increasing level exercises, are helpful to the typology of person afflicted by dementia: open and wide-ranging questions are usually asked when they are addressed to the whole group or in order to help personal experiences to reemerge.

The persons are not put in a position to have a confrontation with their own difficulties, and they only are asked direct questions, expressed in a protected way: close questions or with two choices, in order to allow them to orientate into answer.

Only in case the music therapist considers those answers as based on certainty (and it can be checked both on the verbal side and on the patients' non-verbal communication), the topic can be analysed in depth or the activity can be made more difficult.

The cognitive training which the persons take part to, in addition to the appointed cognitive targets, is directed to highlight their abilities by their recognition, to increase their self-esteem and their sense of efficacy.

In detail, by this intervention, it is possible to calculate if the combination between the R.O.T. and the Musictherapy, by stimulating the cognitive functions in a different way, may strengthen the long term memory, the short term memory and the attention. Other facets, like the mood, the language and the participation level, and the non-cognitive symptoms associated with dementia, are taken into account, but are not considered statistically.

A succession of exploratory meetings preceded the experimental work, in order to single out the patients' needs and peculiarities, and to prepare an adequate methodology.

Before the start, and at the end of the treatment cycle, the Mini Mental State Examination (MMSE) is administered to the participants, in order to evaluate the intervention's effectiveness.

Materials and method

The persons taking part in the experimental work were 17 subjects, all dementia-afflicted women, 76,3 aged on average, with 6,4 school-attendance years on average and 16,9 starting average MMSE level. The control group was made up by the same subjects which had previously followed only the ROT cycle. In those subjects

the starting average MMSE level has been compared with the one checked in the end of the two treatment periods. The sample, divided into 4/5 persons groups, has taken part to a project including the ROT therapy (4 meetings a week), and Music-therapy (3 meetings a week) for the duration of a month of total treatment.

The meetings were organized on account of the personal characteristics of each participant in the group, checked by using a form taken from Benenzon (3), readjusted on our patients' typology.

This form has been administered, before the treatment start, both to the patient and to the caregiver, the main reference relative which takes care of the patient and may help by supplying the music therapist with the information that the patient, because of the troubles he/she is afflicted by, is not often capable of giving but in a disjointed way.

By using these forms it is possible to make the individual's capabilities, musical tastes and experiences reemerge. The form is divided in three parts, dealing with: childhood-youth, adulthood, present moment. The aspects we noticed regarded the music executive capability, the singing and the dancing. While working with geriatric patients, we could verify how different kinds of dance, popular first, were affecting the personal background and might become part of a sort of reminiscence and a spur to the movement, to the coordination and to the sequential execution, which is extremely useful in rehabilitation.

We also drew up some schedules to estimate weekly the course of the variables we analysed: long term memory (LTM, from now onwards the text), short term memory (STM, from now onwards the text), attention, for the listening and the sound production phases. The data were registered by an observer on a provided survey schedule. The statistics we used was the "Student's T test" for dependent samples.

The musictherapy work programme was made up by 45 minutes meetings, divided into three periods of the duration of 15 minutes each:

Listening, Sound Production, Corporeal perception and expression

Together with the music therapist, an observer takes part to the sessions and registers the tendency of the analysed variables on provided schedules, that are afterwards converted into statistical data.

Listening: this phase consists of the listening of a settled track (of the lenght of 2.30 minutes), and of a unsettled track, each meeting.

The settled track is repropose in every meeting at the start of the session. The repetition of this event in every meeting grants a sort of predictability to the session and allows a sense of confidence, recognition, belonging. These are aspects that are more and more missing because of the disease.

This first listening part aims to work on LTM and on the forming-reinforcement of a mnemonic trace, session by session.

Session by session, after the listening and the question of the music therapist about which track it was, the group has constructed a story where biographical moments, recalls, impressions and associations are melted together. In addition to the training aspect, in this phase, like in the others of the session, the cognitive stimulation side is followed by short periods devoted to comments, associations, designating emotionally this experience and aid the participants of the group to communicate and socialize.

After the settled track, a track, that is different in each meeting, is proposed to the others. The music therapist chose the track, by basing on the information obtained from the musictherapy form. This track allowed the group to have experience of several kinds of music: classic music, (instrumental and opera), folk music, ethnic music, marches, national anthems, light music (especially the italian one), new-age music.

The listening to the unsettled track allowed the training of the STM and the recall, and favoured the emerging of personal backgrounds, by encouraging the linguistic production. In some occasions strong emotional happenings emerged, the participants reported meaningful events of their life (mother's or spouse's death); they had the possibility to find them again during this protected setting, and the possibility to express themselves and to be understood in spite of the troubles of their disease.

The tracks we used most are from the italian folk music of the 40' and the 50', particularly the dance songs and from the italian song. Have you ever heard of Claudio Villa? Nilla Pizzi? Waltz and Mazurkas?

Our participants have; these songs are a part of their story and of their musical identity, on the notes of them a conversation, a gesture or a movement may arise. Recalls emerge. The dancing with the soldiers of the american army in the early postwar period: Pina told us of a secret love of hers and on her face, usually impassive, a strong catching emotion appeared. It was a repressed love, which even survived to her marriage and to 50 years of home life with a man of her birthplace in the North of Italy.

Filomena had an angry gesture, she couldn't go to dance because her father did not allow her. Augusta is solidly, her brother was even more possessive than her father, and watched her every time she went out with a boy. It is not easy to recollect these moments, words are not remembered, are confused. But there is a strong will of telling them and with the aid of the music therapist, with a great tact, it is possible to name everything has to be said.

About the unsettled track, there are some considerations it is useful to mention: one day is for mountain songs, one other for Schubert's "Ave Maria" or for "O Sole mio", symphonic tracks, opera and operetta arias.

A listening, and then the naming: "What have we just listened to? Who was singing it? When? And where?" the questions are proportionate to the answers, involving everybody, leaving enough time in order to allow the words to come out, in the end, and some pieces of the puzzle to be put together again, in that spot at least.

The cognitive training carried out by the participants is full of emotions and recalls and it becomes a period of exchange and touch. Even though it is for short, these persons, that are often relegated into an unyielding silence, come back to life and recognize themselves.

In this approach to musictherapy the listening is considered an active process, in a sense of strong global activation.

In this sense it can be considered an important moment for the development of the musictherapy process, both for the activation of the main cognitive functions and for the emerging of recalls, so for the possibility of modulating the mood. The motor activation it can lead to is very important too, and it can be used by the music therapist.

Sound production: this phase is characterized by the use of music instruments, it is carried out by using a kit consisting of drum, rainstick, handbells, triangle, xylophone, maracas.

The choice of the instruments has been made, after some test sessions where these instruments resulted to be particularly fit for the dementia afflicted patient: easily handling, with recognizable shape and material, those instruments are also close to the elderly's from point of view of timbre. The instruments has not been presented all together, each week the patients had the possibility to experience a new one, and to add to the previous one. In this way we avoided any possibility of disorientating the dementia afflicted patient and we proposed a progressive stimulation.

Each instrument is introduced by the music therapist, its name is asked to the group, and in case it is not told, we start the personal exploration of its shape, size, colour, texture and material in order to discover and name it.

In this exercise the linguistic production is particularly encouraged.

In the following meeting the previous sessions' instrument is recalled and added to the ones already known. Like that, we train the LTM, the recall, the recognition.

The music parameters have been introduced progressively: intensity, pitch, tone and we also worked on matching them up in order to train perceptive and cognitive functions. During this phase the sound production is carried out both by the music therapist and by the patients, that are first requested to work separately or in pairs, then to make a sound performance in group.

Increasing level exercises have been structured to train the learning and calculating capabilities and the recognition.

In parallel to the cognitive exercises, the output of improvisations and sound dialogues allowed the patients to work on their emotional experiences, self-expressions reflected on the instrument.

The motor activity tied to the performance, the handling of the instrument allowed some patients to bring out their abilities inside the group, as they had preserved their praxic functions, in spite of the great deterioration.

Thanks to the non-judging atmosphere of the group, nobody refuses this kind of experience. Progressively, the embarrassment disappears and step by step the ladies treat themselves to discover a new sound, to enjoy the effects it gives, to give and receive evocative sounds. Each week a new discovery to make, the name of an instrument to learn, a new sound to recognize, a new melody to play in order to let the others understand its message.

Assunta is considered apathic, nothing of the outside world looks to interest her. But the drum has something that catches her and she doesn't miss it: she gets lively as she plays it, she looks for it and smiles, for her own strenght and will of playing. And she tells us by using an irony we only could decipher from her face, before. After the session, she comes back to her "mask" and disappears into her worrying silence.

One day we discovered the: “silvery sound” triangle: according to Luigia it was like the sound of the bells of her village in Abruzzo, a rural place where she spent her childhood, that she presented to us by telling of the smell of must and of the sunny countryside. Lijuba is Hungarian, she could play the piano. I could not understand her stories, if the piano is now in her house in Rome or it is still in Hungary, where she had to leave from because of the politics matters. But the important thing is that she felt at ease in this music context. She smiled while singing an old song, with unknown words, that was pleasant for the others too, by accompanying with the xylophone that she handled in a skilful and expert way.

Corporeal perception and expression: This phase is characterized by a corporeal activation and relaxation phase on selected musical tracks.

In this last period of the session, still of the duration of 15 minutes, we mostly worked on the corporeal experience that music can evoke.

Since the participants were all women, as the group got more confident, a moment of great privacy and touch set up with their body, that is not only an ill body (due to the poly-pathologies these persons are afflicted by), but also a body which need to be rediscovered, to take care of. The differences of age, of social and financial status disappear; even the pathology keeps in the background.

This last quarter of hour of therapy became a real surprise:

Pia, which was usually motionless, got lively with fast measured movements, making all the others envious. Giuseppina relaxed with the self-massage and her face features looked softened. One day, while listening to an irresistible dance track, they got up all together and started having a waltz. At the end of the session, we went beyond the exit door, still smiling and moving at rhythm while the relatives, who were waiting, looked at us incredulously, and curious about what we had done this time. Usually sad and demotivated, those relatives started smiling again for a while and felt a sense of relief as they saw, even though for a short time, a mother or a wife expressing their vitality and their joy of life.

Trying it again means it is still possible.

RESULTS:

At the end of the experimentation period there has been a comparison between the average in and out MMSE values, both in the experimental group and in the control one. These values are both statistically considerable, with a more remarkable result in the experimental group ($p=0,00033$) compared with the control group ($p=0,0013$). In comparison with the variables previously checked, a remarkable difference can be highlighted in analysis of the LTM, both in the listening phase ($p=0,000338$) and in the sound production phase ($p=0,00017$). As regards the STM, the difference is remarkable only in the sound production phase ($p=0,041$). The variation in attention has not been considered remarkable.

CONCLUSIONS

The results highlight that the musictherapy intervention, structured as I explained and associated to the ROT, contributes towards the preservation and the reinforcement of the short and the long term memory, even by small interventions. The survey on this sample has besides brought out an improvement of the mood, of the verbal fluency, of the group relations and remarkable considerations have emerged on the trend of non-cognitive symptoms such as aggressiveness, apathy, psychomotor agitation, depression. We could assume the effectiveness of this intervention to be due to its characteristic of stimulating the concrete action, the non-verbal communication, the use of many sensory channels in an atmosphere full of spurs, not only technical, relational and empathic, capable of returning a sense and a purpose to the patients' activities, so that they can recover their self-esteem and their sense of effectiveness.

2nd PART

This second part of my work concerns an experiment we held during the period between september 2003 and april 2004 at the Diurnal Center of a clinic in Rome. It is the sequel of the previous work on the methodology of musictherapy, adjusted to the typology of the new patients: groups of fragile elderly persons at the risk of loss of autonomy – for the polypathologies that may arise as the age advances – and persons afflicted by mild cognitive deterioration, and Alzheimer's dementia in some

cases. The purpose of this exploratory work is working on the integration between persons afflicted by different pathologies.

TYOLOGY OF GROUPS

This musictherapy intervention involved 49 patients (32 women and 17 men), attendine the diurnal center for four months in a row during the period of september – december 2003 (25 participants divided into two different attendance shifts, one of three weeks and the other of two) and january - april 2004 (24 other participants, divided by the same criterions of attendance).

In each of these groups, consisting of 10/12 persons, with an age of 80 on average and a school-attendance of 8,6 years on average, there were 3 patients afflicted by mild cognitive deterioration (with diagnosis of dementia) and fragile elderlies, not afflicted by cognitive deterioration.

METHODOLOGY AND AIMS

The musictherapy meetings last 50 minutes each.

The intervention methodology previously described is kept on its basic structure and modified towards a better flexibility of its proposals, closely connected to the new groups' setting.

It focused on the following targets:

Individual targets, in common with all the participants.

1. Cognitive rehabilitation for the preservation of the residual resources (training and strengthening of the long term and short term memory, of the attention and the language),
2. Support of the mood,
3. Reinforcement of the identity and increase of the self-esteem.

Specific targets for persons afflicted by cognitive deterioration.

4. decrease of the non-cognitive symptoms associated to dementia
5. recognizing and bringing out alternative capabilities and vicarious functions in spite of the progressive cognitive decay

Targets for integration by the work in group.

6. Developement of socialization

7. Bringing out the personal contribution in the group, over the specific pathologies
8. Recognizing and bringing out the resources previously noticed

An observer pointed out the course of the sessions related to the aims we had setted, and a descriptive observation register was drawn up, allowing us to do some considerations.

1. The cognitive stimulation exercises are adjusted according to the participant's level where they are practiced individually. The question are made so that the patient, especially the dementia afflicted one, doesn't feel uneasy. The verbal contributes expressed by the participants are collected by the music therapist as informations about the music subject the exercise is based on, and those comments are particularly brought out by the group comment and sharing. The participants attend and accept this training because the non-judging and non-evaluating atmosphere allows even to expose to a possible failure. The group "curbs" the individual difficulties and, from the point of view of the solidarity that is being built, the competition is replaced by the cooperation. This leading mood encourages the personal contribute, the sense of belonging and the respective acceptation of the participants. The group stars working as a "secure base" (quotation from Bowlby)
2. The listening of music belonging to the patients' "Sound Identity", the practice of improvisations, the combination between free movements and music-led movements, are the aspects of the musictherapy group work that look encouraging the improvement of the mood, the sense of identity, as quoted from a self-report written by the participants. In the verbalization that follows those experiences we could find several occasions of expression, recognition and sharing of the emerging emotional background, a positive psychomotor activation, in most of the participants. By a lower verbal activity, but by an exact and understandable non-verbal language, dementia-afflicted persons found a way of recognition and personal fulfilment.
3. even though hardly, the participants started to more appreciate themselves for their own capabilities and competences. The music therapist's non-judging behaviour and the attention to the process rather than to the result, allowed the persons to get rid of inhibitions and to enjoy some music experiences that turned out to be satisfactory and captivating. The occasions where some dementia-afflicted patients received by the others the recognition of their capabilities, for instance in singing, in the rhythm preciseness, in the better expressed emotionalism, have been particularly remarkable.

4. Notes about the effects of musictherapy on non-cognitive symptoms associated to dementia:

according to our observations:

Depression:

Improvement of the mood.

Appearance of evocative elements, experiences, recalls, both during the listening phase and the sound production.

Group sharing, recognition of emotions, strengthening of identity

Apathy:

The musical-sound aspect, both on the listening side and the production, is strongly stimulating and gives rise to activation reactions

Psychomotor agitation:

The musical-sound aspect, both as listening activity and as production, curbs, appeases, diverts the patient (it needs a thorough calibration)

5. The presence of persons afflicted by mild-dementia or cognitive deterioration and persons without this pathology is an experimentation in progress, that allows us to remark that:

Music is a privileged channel for the patient afflicted by cognitive deterioration: compared with the verbal stimulus, it is more effective and captivating. In a musictherapy context, the deterioration afflicted person has many tools at his/her disposal to strike up a relationship with the group and the music therapist. The evocative and the motor elements, we talked about before, allows to bring them out in the group. These aspects, redefined by the music therapist in the therapeutic context, favour the process of integration and acceptance between the patients which are usually banned from the group activities that highlight their disability.

The musical activity in the musictherapy session, in the sound production facet above all, allows a kind of non-verbal communication both on the active-expressive side (the one which plays), and on the receptive side (the one which listens to or receives the message). The participants afflicted by dementia are facilitated in comparison with other kinds of communication, because they don't have to use the verbal channel and they can benefit from the perfectly operating functions, such as the procedural memory. The sound production aid them in this way and contributes to a greater sense of effectiveness, identity and self-esteem.

CONCLUSIONS

According to the points 6-7-8 we can lastly deduce that the musictherapy activity structured that way allows a good integration between the participants, even outside the musictherapeutic context: the patients kept on relating positively, recognizing themselves as members of the same group and they helped each other where necessary.

The first incomprehensions between the participants of the group disappeared as the work progressed, making room to the comprehension and acceptance of the respective disabilities. Some elders not afflicted by dementia told the group about their motor troubles or their heart diseases, diabetes etc., and it allowed to share an aspect of suffering, and to fit into the existential dimension of their age, a period that still gives the possibility of a good quality of life and a better relation with other people and with themselves.

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CHAPTER 45

*Musical features in music therapy
improvisations of clients with
mental retardation*

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Abstract

Improvisation has been used in clinical music therapy with a variety of conditions and can also be used in the education of music therapists as Erkkilä (2000) has reported. Analyzing improvisations is a time-consuming procedure and is therefore mainly applied in research. This study has emerged from the need to make the analysis process faster and more objective, and thus more usable in clinical settings.

The first aim of this research is to automatically analyze musical features of music therapy improvisations by clients with mental retardation, and to compare these

features with assessments done by therapists. The second aim is to automatically analyze musical communication of clients and therapists in terms of synchronicity, soloist-accompanist-ratio and turn-taking.

The research is carried out in collaboration with three districts of services for intellectually disabled (Pääjärvi, Satakunta and Suojarinne) and the Rinnekoti-Foundation where music therapists collect MIDI improvisations as a part of their daily clinical work.

Client improvisation data is analyzed with a Matlab toolbox that has been developed for the extraction of musical features from MIDI. This process is based on previous research on cognitive musicology at the University of Jyväskylä, which has produced computational algorithms for the analysis of rhythm (Toiviainen, 1998), melody (Eerola, Järvinen, Louhivuori & Toiviainen, 2001) and tonality (Krumhansl and Toiviainen, 2000).

Evaluations done by therapists are collected immediately after each improvisation with help of web forms.

Data collection will continue until January 2005, but preliminary results and implications will be presented at the 6th European Music Therapy Congress in June 2004. This ongoing research work is part of research project Intelligent Music Systems in Music Therapy, funded (code 102253) by Academy of Finland and conducted by Ph.D Petri Toiviainen and Ph.D. Jaakko Erkkilä.

Aims of this study

This study is part of the Intelligent Music Systems in Music Therapy project. The purpose of this study is three-fold. The first goal is to develop a procedure for collecting music therapy improvisations. Second aim is to test usability of an automatic computer-based MIDI analysis system of musical features in the clinical setting. Thirdly, after collecting and analyzing these improvisations, possible connections between clinical and musical variables will be investigated computationally.

Institutions involved

Four institutions for intellectually disabled are involved in this study by giving human and material resources in the form of investing in equipment needed and letting music therapists use their time for gathering data from their daily clinical work. A total of five qualified music therapists from four institutions are participating in this study. They are:

- Pääjärvi Federation of Municipalities: music therapists Kimmo Pyhälä and Leila Varkila
- Rinnekoti-Foundation: music therapist Heikki Raine
- Satakunta District of Services for Intellectually Disabled: music therapist Arto Mäkelä
- Suojarinne Federation of Municipalities: music therapist Jukka Värri

Use of improvisation in music therapy

Improvisation is a common method in music therapy practice. Improvisational music therapy has been applied to a large selection of clinical populations including intellectually disabled persons (Bruscia, 1987, 5-6).

Previous research of music therapy improvisations has been based mostly on recording, transcription and interpretation of improvisations. Utilizing sequencer and notation software has been described in recent years (Orsmond & Miller, 1995; Lee, 2000; Wentz, 2000).

This research is an attempt to use automatic extraction of musical features in the area of music therapy improvisation analysis in clinical setting. If the automatic extraction of musical features turns out to be applicable for this purpose, it will allow analysis of large amounts of data in a short time interval. In the future, that will provide a more effective method of comparing music therapy improvisations of various diagnostic groups as well as improvisations during therapy of a particular client.

Practicing clinicians can expect automatic musical feature extraction software to be used as an evaluation tool for clinical work in the future.

Improvisational music therapy has been used with various clinical populations, including mental retardation, learning disabilities and neurological impairments (Bruscia, 1987, 6).

Because of its wide clinical use improvisation is also used in music therapists' education. Erkkilä (2000) has made a proposition for the didactics of music therapy improvisation, where theory and experience is combined.

In the realm of neurological conditions music therapy improvisation as a source for assessment data has been a subject of interest in Alzheimer's disease (Aldridge, 2000) and spinal cord injury (Amir, 1990).

Bruscia (1991) has edited a collection of case histories, where improvisation is reported to be used in 26 cases out of a total of 42.

Besides numerous case histories, effects of music therapy improvisation have been researched more extensively. Edgerton (1994, 33) developed a checklist (CRASS) to evaluate communicative behavior of autistic children ($n = 11$) from video recordings, and found that improvisational music therapy was more effective than a reversal mode of structured music therapy where pre-composed tunes were used instead of improvised music.

Formisano, Vinicola, Penta, Matteis, Brunelli and Weckel (2001, 627) reported that active improvised music therapy improved collaboration and reduced undesired behavior of comatose, severe brain-injured patients ($n = 34$).

Burns, Harbuz, Hucklebridge and Bunt (2001, 48) compared outcomes of improvisational and listening-based music therapy for cancer patients ($n = 29$) and found increased experience of well-being and energy, less tension during improvisation, and measured increased level of salivary immunoglobulin A and decreased level of cortisol in both groups.

Effect of improvisational music therapy in the field of psychiatry has been examined by Maler, von Wietersheim, Schurbohm, Nagel, Feiereis and Jantschek (1994, 122); analysis by means of specially constructed rating scales revealed that patients with psychiatric and psychosomatic disorders ($n = 200$) played louder, were more free in the improvisation and showed more plasticity after 10 sessions of music therapy.

Pfeiffer, Wunderlich, Bender, Elz and Horn (1987, 184) conducted a controlled study with therapy group of patients ($n = 7$) with diagnosis of schizophrenia or

schizoaffective psychosis participating in 27 sessions of free improvisation music therapy and a matched waiting group. Therapy had no effect on psychopathological picture measured on Lorr scales, or on recreational and social behaviors.

Pavlicevic and Trevarthen (1989) developed a rating scale (MIR) to compare improvisations of schizophrenics (n = 15), depressed patients (n = 15) and normal controls (n = 15) and found significant differences in the improvisations of these groups. Pavlicevic, Trevarthen and Duncan (1994) developed further the previous MIR rating scale to evaluate communication of schizophrenic patients. According to the researchers, the therapy group (n = 21) who attended 10 weekly music therapy sessions improved their clinical status and the level of musical interaction measured on MIR(S) scale in comparison to the control group (n = 20) who attended only the first and last sessions.

Bruscia (1987) has developed the IAP model of assessment which demands aural musical analysis of recorded improvisations, and is designed to be used within not one but many possible kinds of interpretations. The large scale and complexity of the model has been a source of discussion and Bruscia (2001) has presented the abridged version of the IAP.

Development of improvisation analysis technology

In the beginning music therapy improvisation analysis was by using a reel-to-reel tape recorder, pencil and an empty sheet of music. This method takes so much time that it is rarely used by practicing clinicians.

Some analysis methods rely on graphic notation like Bergström-Nielsen's (1993) approach. Recording technology has been developed, and saving improvisations on computer's hard disk as MIDI files instead of using analog tape recorders has been a rising trend. Orsmond and Miller (1995) used MIDI recording technology in their study concerning the characteristics of improvisations of children with developmental disabilities. Lee (2000) presented his method of analyzing music therapy improvisations using MIDI recording and software notation as one possibility instead of tape recording and manual transcription into notation. The process in whole in Lee's model is phenomenological and includes many interpretative stages. Wentz (2000) has utilized MIDI recording and the use of notation software in context of Nordoff-Robbins music therapy.

In spite of exploiting computer technology in recording and notation music therapists have not used technology in *automatic analysis* of collected improvisation data. Research of computational modeling of musical processes in the realm of cognitive musicology can help to achieve this goal. Many of these models can directly be applied to algorithmic analysis of music. At the University of Jyväskylä the research of cognitive musicology has produced computational algorithms for analysis of rhythm (Toiviainen, 1997, 1998; Toiviainen and Snyder, 2000, 2003), melody (Järvinen and Toiviainen, 2000; Krumhansl, Louhivuori, Toiviainen, Järvinen and Eerola, 1999; Krumhansl, Toivanen, Eerola, Toiviainen, Järvinen and Louhivuori, 2000); Eerola, Louhivuori, Järvinen and Toiviainen, 2001) and tonality (Krumhansl and Toiviainen, 2000).

Development of music therapy improvisations collecting procedure

Improvisations are collected by music therapists as a part of their daily clinical work at institutions for intellectually disabled. Clients in this study are clients with mental retardation, some other neurological diagnosis, or some psychiatric diagnosis. This is due to increased functional capacity of large units those inhabitants have during years moved to more independent life to smaller units.

Therapist and client improvise together with two separate MIDI keyboards. Unfortunately, the keyboards used have been proven to be of poor technical quality and shall be replaced with keyboards of higher standard. Time or content of improvisation is not limited. Timbre is limited to piano sound because MIDI data does not store information of timbre. A MIDI sequencer software is used to record improvisation. After improvisation has completed therapist exports it in .MID-format as two independent MIDI tracks, track 1 played by the client and track 2 by the therapist.

From there he or she sends it to the researcher. Transmission is web-based. In addition to MIDI files therapist fills in complementary data.

Basic abilities of clients are assessed by a MIDI music test that has been constructed to serve needs of this particular study.

FIGURE 1.

MIDI Music Test

(Underlined = loud spoken)

"Now we are going to play some music. Always listen instructions before we begin to play. When I say: "Play!" according to my instructions.

1. Left and right hand by turns.

Instruction: "Listen: (speak while playing) Left, right, left, right."



2. Left and right hand at the same time.

Instruction: "Listen: Both, both, both, both."



3. Crossing the middle line of body by left hand/ascending pitch.

Instruction: "Listen: I'm playing with left hand."

Instruktiō: "Kuunttele: vasen käsi."

Model: Play all white keys by passing your hand over them all over from lowest to highest key.

"Play!"

4. Crossing the middle line of body by right hand/descending pitch.

Instruction: "Listen: I'm playing with right hand."

Model: Play all white keys by passing your hand over them all over from highest to lowest key.

"Play."

FIGURE 2.

5. Memorizing one unit.

Instruction: "Listen!"



6. Memorizing two units.

Instruction: "Listen!"



7. Memorizing three units.

Instruction: "Listen!"



8. Memorizing four units.

Instruction: "Listen!"



9. Memorizing five units.

Instruction: "Listen!"



10. Piano pianissimo.

Instruction: "Listen!"



FIGURE 3.

11. Forte fortissimo.
Instruction: "Listen!"



12. Crescendo.
Instruction: "Listen!"



13. Diminuendo.
Instruction: "Listen!"



14. Accelerando.
Instruction: "Listen!"



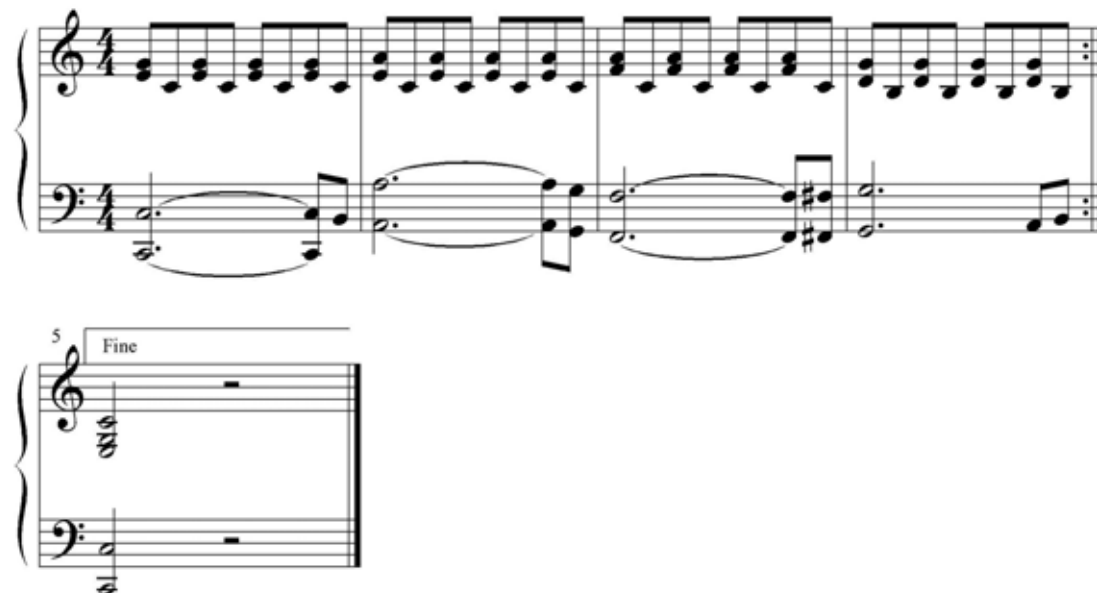
15. Ritardando
Instruction: "Listen!"



FIGURE 4. .

16. Harmony.

Instruction: "Play with me anything you think fits with this. Play!"



17. Harmony.

Instruction: "Play with me anything you think fits with this. Play!"



At first time of the first improvisation, the therapist fills in the basic data form which includes basic information e.g. about diagnosis, and verbal abilities. The fol-

low-up form, that will be filled in every third month, is very similar. After every improvisation, the therapist is required to fill in the improvisation analysis form which includes ratings concerning the client's musical and nonmusical functioning during the session. These evaluations done by therapist compliment the information received from MIDI files.

Relation of automatic analysis system to subjects of clinical interest

Music Therapy Toolbox (MTTB) is a set of MIDI Toolbox (Eerola & Toiviainen, 2004) functions for MATLAB software. MTTB is still at the developmental stage, and more functions will be included and developed in the future.

According to the World Federation of Music Therapy (1996) the function of music therapy is to meet physical, emotional, mental, social and cognitive needs.

Clients with physical needs can have problems in dexterity of upper limbs. These difficulties affect the client's operating area at the keyboard. MIDI data reveals which keys have been pressed during improvisation. Clients who have problems in motor dynamics play the keyboard either without dynamic nuances or use extreme force. This category of problems includes lack of force as well. In MIDI data, velocity value has a ratio to the player's use of dynamics. Also differentiation of fingers can be detected from the MIDI data by looking if there have been played separate keys or clusters. In evaluating MIDI data it is useful to remember that actions can be intentional or not. That is the reason for performing the MIDI test before beginning the actual improvisation sessions. If the client can differentiate his or her fingers but will not do it in improvisation, therapist has a reason to conclude that playing of clusters is a deliberately performed action.

Emotional content of improvised music is a clinically important subject when therapy has emotional or mental dimensions. According to Sloboda and Juslin (2001, 81-82) there are two kinds of (not totally independent) musical emotions: those concerning the aesthetical value of music, and those induced or expressed by music. Gabrielsson and Lindström (2001) have reviewed the research literature concerning the influence of musical structure on emotional expression. Concepts and terms of many researches used in studies since the 1930's are miscellaneous, but many of them are the same as Juslin (2001) has summarized in his presentation of structural components of performers' emotional communication in music grouped in five emotional categories where is the (tenderness, happiness, sadness,

fear and anger being in relationship with dimensions of valence and activity level. Several structural components are partly overlapping in these emotional categories.

Cognitive abilities of a client are apparent in their perception of the instrument and situation as well as in reacting to events. These include hearing and memorizing skills. These can not directly be derived from improvisational MIDI data but are present in communicative actions between client and therapist.

Musical features of social functioning in improvisation situation can be detected by comparing client's and therapist's actions. They can be viewed in graphs of MTTB to find correspondencies in musical features between players. Signs of leading and following can also be seen in graphs. These are especially relevant if client's problems are related to extreme expression of dominance or submissiveness.

MTTB creates a set of graphs. First there are pianoroll windows which represent the content of selected MIDI channels in ascending order. In this case, the therapist's channel is number 1 (blue or) and the client's channel number two (red). Pitch windows give an overall impression of music played.

Density refers to amount of notes per second. Usually, but not always high density is perceived in music with fast tempo, and low density with slow tempo. Fast tempo has in most studies been interpreted a sign of happy emotion, and in some cases anger or fear (Gabrielsson & Lindström, 2001, 235-239).

Mean duration refers to duration of notes played.

Mean pitch gives information about the register participants have used during improvisation.

Pitch standard deviation tells also about use of registers but in smoother manner than previous graph.

Mean velocity refers to speed of tone attacks. Velocity sensitivity is the keyboard's responsivity to the speed which a key is depressed. Velocity sensitivity has a ratio to the dynamics used by a player. Loud sound level in music has been interpreted as an expression of joy, gaiety or anger by listeners, while soft sound level has been represented as expression of sad-toned or tender emotions or fear in various studies reviewed by Gabrielsson and Lindström (2001, 236-240).

Large variations in loudness have been interpreted as expression of fear and small variations have represented happy and active emotion (Scherer & Oshinsky, 1977).

Emotional interpretation of loudness changes has been more a controversial subject (Gabrielsson & Lindström 2001, 236-237)).

Pulse clarity function is still under development being a rather tentative measurement at the moment. Pulse clarity tells us about rhythmic regularity. Gabrielsson & Lindström (2001) have summarized studies concerning emotional interpretation of rhythm. Regular, smooth and flowing rhythm has been interpreted as a sign of happy emotion (although in one study varied rhythm was interpreted as joyful). Irregular, rough and complex rhythms represent controversial matter of expression to listeners, sometimes being labeled as happy, sometimes as angry, and sometimes as sad.

Tonal clarity graph refers to the grade of tonality but not in a certain key. This means that the tonality of improvisers can be as well in the same or different key. Plans to develop MTTB include inserting a major/minor tonality function in toolbox because of vast evidence of major/minor tonality contributing to emotional interpretation of music. This idea has been reviewed extensively by Gabrielsson & Lindström who have summarized studies confirming that listeners connect tonal music to happiness, atonal music to anger and chromatic music either to sadness or to anger (2001, 234-241). Kennedy(1980, 660) has defined tonality as key, meaning particular observance of a single tonic key, and atonality as loyalty to no key.

Articulation presents a value equal to 1 minus silent moments in the current window. According to this articulation gets a small value if there is much silence in the window.

It's useful to keep in mind that this articulation window does not refer to staccato or legato articulation but rather to amount of activity.

Timbre can not be analyzed because MIDI information does not include information of it.

At the present moment this study is still in its infancy. Data collection has begun, but in the shadow of technical problems mentioned previously. These obstacles are not insurmountable, and hundreds of improvisations with incidental form data is expected to get collected and analyzed during the study. Until this work is completed it is too early to predict which the possible findings will be.

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CHAPTER 46 *Voices of authenticity and integrity: A
music therapist's self-inquiry in working*

*with children facing a life-
threatening illness.*

Roberts, Ruth J.

Introduction

Children who are diagnosed with a life-threatening illness are thrown into a world of turbulence where all inner and outer resources are challenged.

Cancer, the second leading cause of death in childhood, requires aggressive and extensive treatment. There are many types of cancer each with its own set of challenges, treatments and outcomes.

For the past 5 years I have worked on a paediatric oncology ward. It has been my privilege to work directly with children and their families as they negotiate their way through lengthy treatment protocols and frequent hospitalizations. It is important that music therapy serves as a strengthening, life-giving force to assist such children on their paths. In music therapy a place is offered where fears, anxieties, grief and pain may be acknowledged and held. Here a child finds opportunity to create beauty and life in the midst of suffering.

Although most children are treated successfully, each year approximately 60 children in the Oncology program die. I often work with the children and families as the child's life ends. Although there is not a palliative care unit in the hospital, a two/day week music therapy program has been initiated to offer service to children receiving palliative care at home. Children served include those with metabolic, neurological or genetic disease.

Nothing in life fully prepares one to accept the death of a child, a human being full of promise and hope. Bearing witness to the suffering and death of a child is no small task. In this process it is important that I, as therapist, am not overwhelmed by the enormity of the need or the ensuing painful emotions the work inevitably evokes. It is incumbent upon me to remain strong and healthy within my own body and spirit so that I may have the capacity for the work. Among other challenges this work demands an ability to be fully present, to be vulnerable and to be authentic.

The purpose of this Masters research is to conduct an in-depth analysis of my perspectives and responses in caring for acutely ill and dying children and in particular to explore elements of authenticity and integrity in the work.

For purposes of the study, integrity is defined as: 'soundness, the quality or state of being complete or undivided, and completeness' (Webster's Collegiate Dictionary, 1993). I am asking: What does the work teach me about soundness and completeness? How can I be sound and complete in order to do this work well?

Authenticity is defined as ‘not false: real, actual; true to one's own personality, spirit or character’ (Webster’s Collegiate Dictionary, 1993). I am asking what does the work teach me about being real and how can I be true to myself in this work?

In my practice I found that the usual clinical form of writing and reporting did not express the essence of what was transpiring in the sessions. I observed that there were things going on, ‘important things that I could not acknowledge’ (Bereznak Kenny, 1998, p.204). I felt the need to "find a language which more accurately described my experience with clients” (p. 211). .

While comparing aspects of various research methodologies, I learned that poetic transcription is “the creation of poem-like compositions from the words of interviewees, and re-presenting or re-framing a story into a creative form of writing” (Donnell, 2003). For some time I have been describing clinical work in creative narrative form/poetic form as a means of satisfying my need for self-expression and self-care. As I reviewed some of these writings, I realized they were a rich resource for my quest, and that, indeed, I had a language which was congruent with my clinical experience.

Recently, I have incorporated sketching into my personal self-care practise. Drawing images related to painful or meaningful personal and professional experiences has given rise to additional insights and inner healing. I have chosen to include some of these in this work.

In this research paper as I explore issues of authenticity and integrity I ask:

What are the elements of authenticity and integrity in this work?

How do I foster it in myself and my clients?

How can I convey the essence of the work in an authentic, integrated way?

Epistemology

As a qualitative researcher I bring a unique perspective to this study, shaped by beliefs and values, both personal and professional.

I believe that connecting with people in a meaningful way presents opportunity for healing and growth. When one human being is truly present to another without an

agenda, doors are opened. I believe the answers lie within; it is best that people, when given support and opportunity, find their own way, rather than be directed by another- and that this approach affords the greatest respect to another human being. I have deep respect for the wisdom of children and believe that they teach us much about what is truly valuable in life. I believe that each human being is called to create and that we are born with an innate yearning and ability to do so and that it is necessary to health.

I believe that the worth of each human is immeasurable and that the significance of their existence, however long or short, is eternal. I believe that music is one way the eternal is represented in each human being.

I believe in the power of story. Story is a way of expressing the essence of experience, and placing it within a greater life context. I believe it is vital to effective music therapy that I pursue my own quest for integrity and wholeness in order to remain vibrant and to facilitate growth and healing for my clients. "Making ourselves whole is an ongoing process" (Bereznak Kenny, 1998, p. 215).

Methodology

This is a qualitative descriptive study. It is concerned with process rather than outcome and evolves from my own work. It describes experiences, asks open-ended questions and can be adapted as the research develops. My position as a researcher includes ongoing self-reflection; my subjectivity is considered a resource. My motivation for this study is as a professional caring for very ill children. And the data reflects a real-life clinical setting.

The study contains elements of heuristic, adapted phenomenological and narrative methods.

Heuristic methodology is a 'process of an internal search through which one discovers the nature and meaning of experience' (Moustakas, 1990, p. 12). In revisiting the data I am committed to ongoing introspection, reflection and interaction with the text. I do not maintain a safe distance or assume an objective stance. But immerse myself in the data, interacting with it on various levels. I am committed to 'risk the opening of wounds and passionate concerns and to undergo the personal transformation that exists as a possibility in every heuristic journey' (Moustakas, 1990, p. 14). I am applying the intuition I have gained from many years of life, professional experience and commitment to my inner healing, spiritual and psycho-

logical growth. I am investigating in new ways, examining stories, poetry and the pastel sketchings which were created as part of my professional and personal journey.

This study employs three types of adapted phenomenological methods:

Applying the reflective method I use my own experience as data to engage in a process of reflection and clarification while attempting to describe the essence of the experience. Empirical methods include reading descriptions, extracting significant statements, finding themes, categorizing and formulating meanings.

In addition, I describe the experience faithfully and engage in an internal dialogue to uncover multiple descriptions the encounter (Young, 2003).

Narrative inquiry is a way of knowing defined as the telling of one's story. In this telling, one seeks to present experience in order to clarify, justify and find meaning (Nye, 1997 p. 441). In using this method I uphold 'the value of learning to hear story through music and finding ways to bring this into our research efforts' (Aigen, 1996, p. 30). The stories are not only presented as data to be analyzed and categorized but be engaged in.

DATA COLLECTION

The source of my data is secondary. Materials include poems, stories, and sketchings done in response to specific naturally occurring experiences during the course of my clinical work.

I reviewed six pieces of writing done over a period of two years. These writings are direct accounts and selected from a collection of writings that were written spontaneously following experiences that were significant to me in my clinical practise.

Data generated by the research includes levels of ensuing dialogue with the original text. Some sketches were a spontaneous expression in response to my clinical work; others were generated by the research process as I revisited the stories, thereby providing additional data.

Using various art forms to process internal issues is congruent with the work of music therapists. I use the art forms of creative writing and pastel sketching to preserve the integrity of my experiences as well as to communicate them.

By preserving my experiences in story form over time I accumulated potential data. Over time, I observed the nature of the unfolding stories as a whole.

DATA ANALYSIS

The data was analyzed on different levels. I followed Husserl's phenomenological 'free fantasy variation' by revisiting the clinical stories through imagination, intuition and further dialogue (Bereznak Kenny, 1989, p. 61) for purpose of gaining perspective, identifying themes, coding and categorizing. The essential elements gleaned reflect only my view and interpretation, not the clients.

The data was analyzed through peer checking – in a research workshop with 6 Masters students and 2 Music therapy Professors. I submitted the stories to two PhD supervisors who reviewed the data and checked my analysis. The categories were then revisited and data reconsidered to reflect final changes.

The stories follow and are accompanied by the result findings. All names are pseudonyms.

- a) Three of the six stories used in the original masters paper are included in this presentation. Each story or piece of writing is presented in its entirety. Two of the stories include subsequently added dialogue with the text, revealing my remembered emotional responses including those evoked on re-reading. One of the stories has a short reflection added following the original text.
- b) Six voices of authenticity, as identified in the data, are presented: paradox, struggle, life, spirit, self and music.
- c) Relevant literature and existing resources are considered in relation to the text and issues that arise from it.
- d) Sketches with commentary are included throughout.

STORIES

VERA AND GINA

All three children in one family I see have had neuroaxonal dystrophy - a rare genetic disorder in which a child develops normally until toddler hood, and then gradually irreversibly loses all neurological and physical functioning. I met this family, six months following the death of their ten-year-old son and a year after their youngest daughter started showing symptoms. Their thirteen-year-old daughter remained alive, with no external visible response. Both girls required twenty-four hour nursing care.

I provided a listening environment for Gina, the older child. Initially Vera, who is 3, was able to attend to music by turning her head, with occasional facial expression and vocalization. In the ensuing months she lost even this ability to respond.

REFLECTIONS

Music therapy in this home presented me with one of my greatest challenges. I knew the children would not recover – that they could live more years or might die at any time. I could not assess music therapy given usual standards. However, in time, I came to realize the significance of the music for their mother...that by offering the girls music therapy I was agreeing with that their lives were indeed, invaluable and that they were worthy of something lovely and beautiful.

Mom shared pictures of her children as happy vibrant toddlers prior to the onset of illness. As I sang to the girls I could easily imagine them as beautiful children at play. I often felt a sense of connection and would sing to them of their loveliness.

One day I had an experience which stood out in my memory as significant yet I found myself reluctant to write about it because it wasn't 'clinical' and because it defied language.

I was providing instrumental guitar music.... wind chime music.... Matching in and out respirations with 2 note step-wise melodic vocal phrases.

“Later I held her hand and sang in a meditative style....

I began singing of a 'little pink flower', attempting to relate to Gina's spirit, as her mind and body were not capable of reaching out.” The music was a celebration of her beauty, loveliness and innocence.

Is there a time when the client's music is created through us? My sense was that this was such a time. Through a deeper connection, which I choose to call spirit, I was able to give voice to her 'flower song'. In this way I served as a vessel because she was not capable of singing her own song.

SKETCH

During the writing of this paper Gina died – I had not been working with her as I was off for a year to attend school. In reflecting on her life and death, and as a personal tribute I did a sketch. For me it expresses the essence of Gina a 'little pink flower' - her spirit open and freed, its essence ever expanding on its rise to eternity.

When I returned to work after my studies, Mom showed me many pictures of the funeral. Gina lay in her coffin, dressed in a simple white dress. Then I noticed the material. It was patterned with little pink flowers.

FIGURE 1.



In the following story you will hear my voice reading the original text and a second voice, which is my response as I began interacting with the text.

BOCELLI, BEETHOVEN AND A BOY

Saheem was a 14-year-old boy undergoing chemotherapy for cancer and had demonstrated autistic tendencies throughout life. He lived in a loving home with dedicated, caring parents.

It feels so strange to be introducing him by his diagnosis, because I honestly don't think of children in this way. It's such a relief from my days of nursing. In music therapy I am free to identify people by their potential rather than their pathology.

The first time I saw Saheem he announced that he liked classical music and could play the piano.

His enthusiasm was infectious.

Unfortunately I do not have a music therapy room or a piano, but there is a small keyboard on the unit. He was thrilled when I gave it to him for use during his hospitalization. The nurses enjoyed his music and saw another side to this boy they knew medically.

The music opens up more of a person, so the staff can appreciate a child in new ways. By giving expression to this vital part of him, Saheem was validated and reminded of who he was.

On this particular day Saheem invited me to view a video of Andre Bocelli, his favourite opera singer. Together we listened to the performance of "Time to say Goodbye". As he listened, tears streamed down his face.

I remember thinking..."Well this isn't really music therapy because a) It's a tape and b) I'm not 'doing' anything. (These music therapy police rear their ugly heads often during the course of my work!)

Dad, a lovely and gentle man said, "Ruth, lately he's been crying when he hears it.... maybe it's related to the words."

I was moved and touched by this man's sensitivity and gentleness. He knew how to just 'let it be'. He had no need to intervene in his son's private moment. A child's pain indeed can be a terrible and frightening thing. Sometimes an added burden for the child during such illness is a need to spare their loved ones pain. Giving expression to some inner sadness which music listening allowed, was important for Saheem to do.

Saheem had a wonderful sense of fun and gusto. One day his hair began to fall out, an expected side effect of the chemotherapy.

I waited to see his reaction.

He picked up a strand or two from his pillow and announced, with great excitement "HEY, my hair is falling out."

I anticipated some expression of anxiety and wondered what would come next.

Then he thought a moment and said, "HEY DAD, Beethoven was deaf, Bocelli is blind AND I'M GOING BALD!"

We burst out laughing.

A few moments later he mused...

"A deaf composer, a blind singer and a bald pianist."

This unabashed humour was completely unexpected and wonderfully refreshing. It speaks of S's vibrant playful spirit, which remained very intact in the face of losing his hair, an experience that can be a threat to a child's self-image. Saheem knew that his place and he clearly ranked in the company of other great musicians!

MELISSA

I met Melissa as a beautiful 18-month-old child. Her parents had been given the news 6 days earlier that there was nothing more that could be done medically to treat her brain tumour. Her life expectancy was four to six weeks. I visited her twice in her home. The first time, after an initial period of shyness, she responded very strongly to the music. Curious and inquisitive, she gathered all her favourite instruments near. She beat steady rhythms on the lollipop drum. And smiled and directed mom to play the drum.

It was hard to believe that she was only expected to live a few more weeks.

Soon mom, Melissa and I were making rousing, beautiful music. She threw her arms over her head in jubilant delight.

...Moments of joy....

Four days later, she was showing signs of deterioration, with obvious increasing CNS (central nervous system) impairment.

Her mom was clearly in shock and distress. She child and had been with her day and night since birth.

Four days later Melissa was hospitalized for pain management. Greeted by her mom in the hospital hallway I noted how thin she felt in my arms - this little mother, who was being forced to relinquish her only child. Melissa was being held by her father. Grandma, newly arrived from China, was nearby. Sisters, cousins, relatives from near and far moved and out of the room. Dad constantly stroked Melissa. Her parents spoke freely of her loveliness expressing amazement at how quickly she had deteriorated. They talked of what a special child she was - how everyone was drawn to her.

Even though Melissa's life was so short, this remembering was a necessary preparation for those she would leave behind.

Mom stated that 'this' has brought the family together, created a strong bond.

I felt mom was struggling to find some greater meaning in the tragedy.

Grandma had arrived from China on Monday and it was as if Melissa had known her instantly. She smiled and laughed "more than I've heard her laugh in a long time", Mom said.

Mom had only met grandma once. Melissa had never met grandma before. This meeting and instant 'knowing' between them brought comfort to mom.

The day after her visit with Grandma Melissa quickly deteriorated. What a wonderful gift that grandma arrived in time to share in the beauty of this little person!

In the hospital room Melissa's parents played her favourite Mozart CD, smiling, laughing and remembering her life. "Maybe she's an angel who was sent for a little while", mom mused.

I recall their commitment to moving heaven and earth to help their child.

I recall the encroaching despair when nothing was enough.

I talked to the family of how she loves them too. I listened to them revel in their daughter's uniqueness and beauty. We spoke of her remarkable affinity for music; we remembered the way she knew immediately what sounds she liked or disliked, how well she communicated, without words, Her parents had started a piano fund.

It was such an honour to know this little person...

As the music ended, I started to sing quietly to Melissa, who was asleep, perhaps unconscious, in her dad's arms. Melissa you are beautiful", and "Thank you for coming", adding out loud, "Even though it wasn't long enough".

"Your voice is so soothing", mom said.

I asked, "Could I bring my guitar?" They were very happy for me to do so.

I returned with the guitar. At the sounds of the first strums everyone came into the room gathering around Melissa.

The music was bringing them together.

Dad constantly rubbed her head and cheeks saying,

"I wish I could just touch the tumour away".

A father's anguish...

Some wiped away tears to the strains of lullabies and peaceful, soothing songs.

Mom broke the mood by saying - "If Melissa was awake she would say, 'YEAHH-HHH', as she threw her arms over her head.

We laughed then moved to upbeat celebratory music, then mom, recalling how Melissa loved the bells and the drum, gathered the lollipop drum, tambourine, shaker and handbells. Mom took the drum and began to beat. Soon both grandmas picked up an instrument and added rhythms to our music.

We continued. I improvised and the music surged and swayed. Although we could not speak the same language we were together in the music supporting this child, giving her strength I hope for her journey and while holding her parents as they could only watch her go.

It seemed mystical.

As the music closed grandma gave a final cadential shake of the colourful seed shaker. Everyone laughed and smiled.

But the Grandmas continued...playfully picking out music.

Dad explained, "They are remembering the music from when they were young, in the 50's in China..."

Ahh....more remembering ...across the generations...

There was something lovely, in that moment. This beautiful child, surrounded by love and celebration and music, and laughter and tears... This child, destined for another place was surrounded with the love and music of her family, her ancestors.

A close family friend arrived with two pairs of new shoes...lovely little pink sandals, and nice dress shoes...

"She will need those in the summer" said her mom.

"They will go with her."

The burial ritual of sending the body off with gifts was not widely understood among the staff. Some were afraid that mom was in some form of denial. I might have wondered the same had I not known her and her religious beliefs.

FIGURE 2.



Voices of Authenticity and Integrity

Initial analysis of the stories revealed several categories defined by specific phrases that emerged from examining the data. From the initial analysis six voices are identified and described: paradox, struggle, life, spirit, self and music.

VOICE OF PARADOX

Working with very ill or dying children presents a profound juxtaposition of opposing realities:

- Laughter in the face of adversity
- Adult wisdom in a small child
- Celebration and play in the midst of sorrow
- Order within chaos
- A vibrant spirit in a dying body
- Time/Timelessness
- Holding on/Letting go
- Hope against hope
- Reality in fantasy.

Bereznak Kenny writes, "When paradox exists, perhaps it is best to embrace, articulate and elaborate on its elements rather than avoid them" (1996, p. 63).

Paradoxes are woven through all the stories.

The courage of each child and family to face and embrace paradox serves to teach me as a therapist to do the same.

VOICE OF STRUGGLE

"Look long and hard at the things that please you

Look longer and harder at the things that cause you pain."

(Colette in Sourkes, 1995, p. 167)

The authentic voice is one of struggle. Parents struggled to face each day in choosing life over death and I struggled to hear the laments - to bear witness to the tears, sadness, anguish - to endure the unknowing and to stay present. I struggled to make sense of that which was not sensible. Even as I knew each child's beauty and

revelled in their joy, I struggled to understand how they could suffer and die. I struggled to know why families who battled through years of illness in the end had to watch their child die. I struggled to accept that there are no answers.

SKETCH

At one point I grew “sick and tired of babies dying”. I sketched tiny forms with big black X’s obliterating – a black force sweeping down to carry them off.

Yet there are hues of pinks and blues - hints of my belief that they are in a better place.

FIGURE 3.



VOICE OF LIFE

Many words of life were gleaned from the stories:

Play/Dance

Joy

Aliveness

Sweetness

Exuberance

Choosing life

Laughter

Fully alive

Humour

Fantasy

Simplicity

Loving

Children, unlike adults, remain very close to play even when they are very ill. Their imaginations are easily activated and they are easy to engage.

Dr. Barbara Sourkes, a psychologist specializing in the treatment of children facing life-threatening illness, cites the importance of play or fantasy in assisting a child to master his/her experience. "The overwhelming nature of the illness cannot be approached by reality alone" (1995, p. 6). Music therapy offers a child freedom to play, to create and to express.

Play is not only important to a child but serves as a comfort and relief for loved ones. Aasgaard, a music therapist who works in paediatric oncology, notes. "The parent's stories from the last period of their children's lives often focus on creative acts and play, the child's enjoyment of music, or simply humorous events" (2001, p.180). This parallels my experience in which parents expressed finding particular

comfort in memories of the moments of joy or pleasure a child experienced during his/her last days. In the midst of demise something of the child was preserved and celebrated. There were shared moments of joy in play, moments of life in the midst of distress.

VOICE OF SPIRIT

Facing issues of life and death propels people to the place of their own spirituality. People in pain or distress will seek comfort and healing, often accompanied by the search for a sense of meaning. Helen Bonny asserts, "If we work in depth with a person we have to deal with the spiritual aspect of his or her person" (2001, p.61).

There are three spiritual needs a clinician must support: a sense of hope, a sense of meaning and purpose, and interconnectedness with others (Davies et al., 2002).

In my care of the dying I have often reflected on the role of hope near the end of life. I have noticed that although the focus of hope changes shape it is always present for both the parent and child. Hope, then, is integral to life - even as life is ending.

Parents often seek a greater meaning from their painful experience. Melissa's mom said 'this' has brought the family together...creating a strong bond. "Maybe she's an angel who was sent for a little while", mom mused. Children, thrust into the world of illness develop wisdom beyond their years, seeking meaning from the experience.

Interconnectedness with others is the third important spiritual need. Alliance with significant others including health care professionals, fellow patients, and friends serves to reinforce a child's sense of place and belonging in the world. Children often forge deep bonds with others who are undergoing similar experiences. Interconnectedness is also realized through remembering and gathering. Melissa's family gathered around her - they talked freely of her loveliness, of what a special child she was, of how everyone was drawn to her. Family and friends from near and far gathered around her bedside. Music from present and past generations filled the air. This gathering and remembering was a necessary preparation for those Melissa would leave behind.

Music supports a deeper connection of spirit. In the world of spirit temporal parameters fall away. Here we enter sacred time and space. Aigen (1998) refers to the sacred world as one, which is "infused with power and an eternal sense of being and reality," (p. 154). Here time assumes a different order. Eliade describes sacred time as "differentiated, circular and reversible...where the events occurring at cre-

ation are always recurring” (p. 154). When singing to Gina, through a deeper connection which I choose to call spirit, I was able to give voice to her “flower song” when she was not able to do so.

“Children have an unobstructed relationship with the Infinite” (Dossey, 1996, p.108). Many gifts of this relationship abound in children facing life threatening illness. Laughter, play and humour bubble close to the surface. Simplicity and love remain strong in the most adverse circumstances.

VOICE OF SELF

“The psyche or soul of the work is contained in the individuality of each and every therapist “ (Bereznak Kenny, 1989, p. 8).

To be able to enter the world of the other one must have an awareness of oneself. It is my belief that the more deeply a therapist knows herself the more fully she will be available to the client. Examination of the stories, initial dialogue and reflection reveals much about me, my role, my issues and what I bring to the music therapy relationship.

I struggled with my role as music therapist...I was constantly aware of the burden to “prove” music therapy and to “prove” that it can do what other therapies cannot. This expectation of self can become unrealistic.

There are many ways in which I used my self as well as the voice of my ‘self’ in music therapy. As therapist I am a listener. “The art of listening is ‘central to the human existence’ and necessary in developing meaningful relationships with fellow human beings” (Nichols, 1995, p 16). By the very act of hearing one validates the existence and experience of another. Listening is at the heart of music therapy (Lee, 1996). McMaster describes listening as a sacred act (Bereznak Kenny, 1995, p. 72).

In my experience as a registered nurse and a music therapist I’ve learned to listen to what is beyond the words and behavior in order to get a sense of what is really being expressed.

To enter a child’s world the therapist must be able to play. Sourkes (1995) advises, “The therapist's willingness and ability to enter into play are of utmost importance. Shared imaginative play enables the child to confront the realities of life and death” (p.7).

Perhaps the most potent aspect of using my 'self' is that of bearing witness.

"To witness is not a passive process....In working with a child facing the possibility of death, the therapist must be able to enter the threat with the child...accompany him or her through the steps, while knowing that this may be a journey that they cannot complete together" (Sourkes, 1995, p. 168).

I accompanied Melissa's family as they walked the final path with their child and bore witness:

- to shock and disbelief that her life would end
- to joy
- to the searching for a greater meaning
- to a parent's raw anguish
- to helplessness
- to courage
- to play
- to sorrow
- to deep connection
- to letting go
- to remembering.

The authentic use of self requires an awareness of transference and counter transference issues which are part of any relationship (Elson, 1986, p. 67) Transference is to be used as a means toward wholeness; however for this to happen the therapist must possess a high degree of self-awareness, be willing to admit mistakes and be able to learn about him/herself without reacting defensively.

I recognize that the exhaustion I have felt is not just because the work is emotionally draining but that the sense of loss, current and anticipatory grief is also being transferred to me from the clients and families. I am aware that my own intense grief for the loss of my own family member will affect me as a therapist. I have a new awareness of cultural counter transference. I know that my responses are based in cultural values often different from those of the patients/families with whom I work. Most cultures have deep beliefs, established rituals around illness, grief, dying and burial.

Buchner suggests that one's story is woven together with the client's. The children's stories affect my life and reflect my own truth (Frank, 1995, p.23). That the lives of

my clients may be woven into my own is a new thought for me. Do I dare to believe this? Am I ready to accept this vulnerability?

In working with critically ill children I am compelled to embrace my own weakness and woundedness - my own 'dyings' so to speak. I am reminded of a prayer, "On each of my dyings shed your light and your love." (Anon.)

It is not possible to isolate the personal from the professional, but it is imperative that an ever-present awareness exists of the influence of one upon the other. In knowing my own woundedness I find I am able to treat another's with a sense of deep respect, recognizing it is sacred. I am less likely to approach with a sense of "helper" than with a sense of "one who has been helped". I move with less authority and more a simple "being with". Working in this way requires taking time to listen to my spirit. It means listening to all of my inner voices so that my "inner place" which opens to the child in therapy, remains uncluttered. I cannot be truly present if I am full of my own stuff.

VOICE OF MUSIC

Someday as we are all quiet

the sun will stop shining

and the world will stop.

All that will be heard

Is music.

(Amy, a child in Sourkes, 1995, p. 134)

The place of music in care of the dying is multifaceted.

Music brings comfort. Often children request nursery songs. According to Winnicott, this music from early years serves as a transitional object - a bridge between the child's inner psyche and his/her recognition of the outer (p. 16). This familiar music was something a child can hold on to as a form of mother comfort to help withstand the intense emotion of their reality.

Music allows for expression of paradox. Music-making provides children with an opportunity to express conflicting aspects of their realities - fear, anxiety, comfort and love.

Music's capacity to look "beyond the illness to the person" (Pavlicevic, 1997, p.93) creates dignity. Of Melissa I wrote: "It is as if something of the child was preserved and celebrated in the face of demise." Thus beauty can be known and upheld in a place of loss.

Music reveals self. I have often witnessed that music opens up the child thereby allowing the staff to appreciate him/her in new way.

Music gives courage. Music can give the child courage to look at the things that frighten or cause pain. Music makes it possible to play and to embrace sadness with courage.

Music supports expression of emotion. Grief, rage, regret, hope and resignation are common emotions expressed by families in palliative care. Music is a safe place for a myriad of emotions to be felt, released and communicated (Salmon, 1993).

Music listening gave expression to Saheem's inner sadness. It offered a place to receive such expression, to acknowledge its truth and to offer an authentic response. Music is a container. It provides a space that provides safety and support (Bereznak Kenny, 1996).

Music is an ally. Saheem's father wrote, "The music therapy... made the intense chemo (therapy) and side effects bearable". The music helped Saheem know that he wasn't alone facing his challenges, helped him bear his difficulties.

Music is caregiver. Sometimes "the therapist's work is far more that of a care-taker; the therapist may have to create music for, rather than with the client (Pavlicevic, 1997, p.151). I created music for Vera and Gina. In this way, the music itself served as caregiver. I have observed that music draws people to a place they need to go, invites them in, offering them the courage to do so. Then it does its restorative, transforming work. Music does all of this with a power and gentleness that is quite beyond that of the therapist who is simply the vessel.

Music is presence. In music therapy, through reflecting the client's music, I am 'being with' the client (Pavlicevic, 1997, p. 152). Music creates an intimacy between people. This togetherness is a place that is too deep for words and becomes a healing presence.

Music's innate capacity toward organization – to bring order out of disorder makes it well-suited for work with very ill children, whose entire world is disordered.

Music affirms life. By offering Vera and Gina music therapy I agreed that their lives were, indeed, invaluable and that they were worthy of something lovely and beautiful.

Music supports remembering. The music supported a coming together of Melissa's family for her important passage. Music celebrated the connection with grandma - a knowing beyond words. It prompted celebration, mourning, and reminiscence.

SKETCH

And what of the music in the midst of all this dying? Was it of any value? I began with the bass clef in verdant green, a colour of life. Soon, it assumed a dance-like form surrounded by music (yellow tones). At first I thought this depicted my music, but I think it is the music of the child. In the midst of dying, music is a call to life. It connects with that which is life giving and becomes a rich inner resource.

FIGURE 4.



FIGURE 5.



Discussion

This study has been an inquiry into authenticity and integrity in clinical music therapy with very ill or dying children. The research gains credibility because the methodology is appropriate to the purpose of this study. Heuristic methods allow for a careful inward look. Narrative methods support the telling of the story – an effective and appropriate way to describe the clinical work. Phenomenological methods find the essence.

The dependability of my research is insured through repeated reviews of the data at different times and levels. Each story was revisited several times for the purpose of gaining perspective and identifying themes. The themes were carefully coded and categorized. In reviewing data all attempts were made to identify relevant characteristics of the topic under study. The findings were obtained through a consistent analysis of the data. The outcomes presented are my own perspectives. Peer debriefing lends credibility to the research.

By reflecting critically on my own interpretations I employed disciplined subjectivity (Ahonen-Eerikainen, 2003a). Because I am trained in detecting counter transference, the subjectivity was also controlled.

These stories, collected over time, are representative of my experience in general thereby lending transferability to the conclusions. Each story is unique and impossible to replicate in exactly the same way. However it is expected that if six similar stories were analyzed in similar fashion the results would reflect the findings in this study. I believe the findings are useful for other music therapists working in emotionally intense situations.

This study possesses 'verisimilitude' which is described as follows:

'When such written accounts contain a high degree of internal coherence, plausibility, and correspondence to what readers recognize from their own experiences and from other realistic and factual texts, they accord the work a sense of 'authenticity' (Atkinson in Denzin & Lincoln, 1998) p. 88.

I have accepted full responsibility for the data and for what I did and did not do with it. The data was not manipulated to reach any conclusions. Throughout this paper I remained true to the data and true to myself, thereby remaining authentic by following Aigen's premise;

“Authentic is being who I am. It is an at-oneness between consciousness, intentions, experience and action. As a researcher, authenticity is manifested in the kind of research I do, how I focus my efforts, the way I collect and process data, the discoveries I make, and how I communicate them.” (Bruscia, 1996, p. 105).

Aspects of authenticity and integrity are found in the results. By embracing paradox and struggle, one learns to be real; the superfluous falls away. Through embracing life and spirit, one is deeply sustained. Through care of self, one is able to maintain emotional and spiritual health. Music is a gift of offering people a place where something of significance can happen. In music, both the client and the therapist are held and transformed.

This research process has been beneficial on a personal and professional level. I have become more integrated and true to myself in the work. I am embracing the notion of client as healer, with full awareness of counter transference. I am particularly struck with the life, joy and beauty in this work as revealed in the data. It is these aspects of the work that compel and propel one to continue. The stories of children’s lives have served to teach me: to embrace paradox, to struggle, to be fully alive, to live with spirit, to examine myself and to let the music do its work.

The stories have assured me that all things have their place and must be maintained in some form of balance. To ignore any one thing would be to lose the richness. To be ‘sound’ and ‘real’ one must embrace the life-changing experiences offered in this work with courage and humility of spirit.

As I reflect on this process I am left with new wonderings...new questions.

The music itself bears examining...particularly the vocal and instrumental improvisations. An examination of endings in music would inform the music therapist working with people whose lives are ending. I will incorporate music improvisation as part of my self-care in this work, much the way I have begun to incorporate sketching. A deeper orientation toward self-knowledge and self-care may be appropriate in music therapy education so that a therapist may be more fully available to his/her clients. The role of creativity in care of the dying bears inquiry.

"The people who come to us bring their stories. They hope they tell them well enough so that we understand the truth of their lives. They hope we know how to interpret their stories correctly. We have to remember that what we hear is their story" (Buchner, 2001, p. 137).

It is hoped this paper, has been true to the children in my care in understanding the truth of their lives.

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CHAPTER 47

*Music therapy training within the
European higher education system: A*

*survey on music therapy
training courses in
Spain*

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1.- TOWARDS THE EUROPEAN HIGHER EDUCATION AREA: THE BOLOGNA PROCESS

The construction of a European Higher Education Area (EHEA) by 2010 is one of the most important objectives of the European Ministers of Education to promote the co-operation of higher education institutions within Europe. Within the framework of the Sorbonne Declaration (1998), the Bologna Declaration (1999), the Prague Communiqué (2001) and the Berlin Communiqué (2003) different action lines were done in order to achieve the aims of the Bologna Process and the Harmonisation of the architecture of the European Higher Education System. Table 1 shows a summary of the action lines in the construction of the EHEA.

TABLE 1. Summary of the action lines introduced in the construction of the EHEA

| DECLARATION | ACTION LINES |
|--------------------------|--|
| SORBONNE 1998 | A progressive convergence of the overall framework of degrees and cycles in an open European Area for Higher Education |
| BOLOGNA 1999 | <ul style="list-style-type: none">• Adoption of a system of easily readable and comparable degrees• Adoption of a system essentially based on two cycles• Establishment of a system of credits• Promotion of mobility• Promotion of European co-operation in quality assurance• Promotion of the European dimension in higher education |

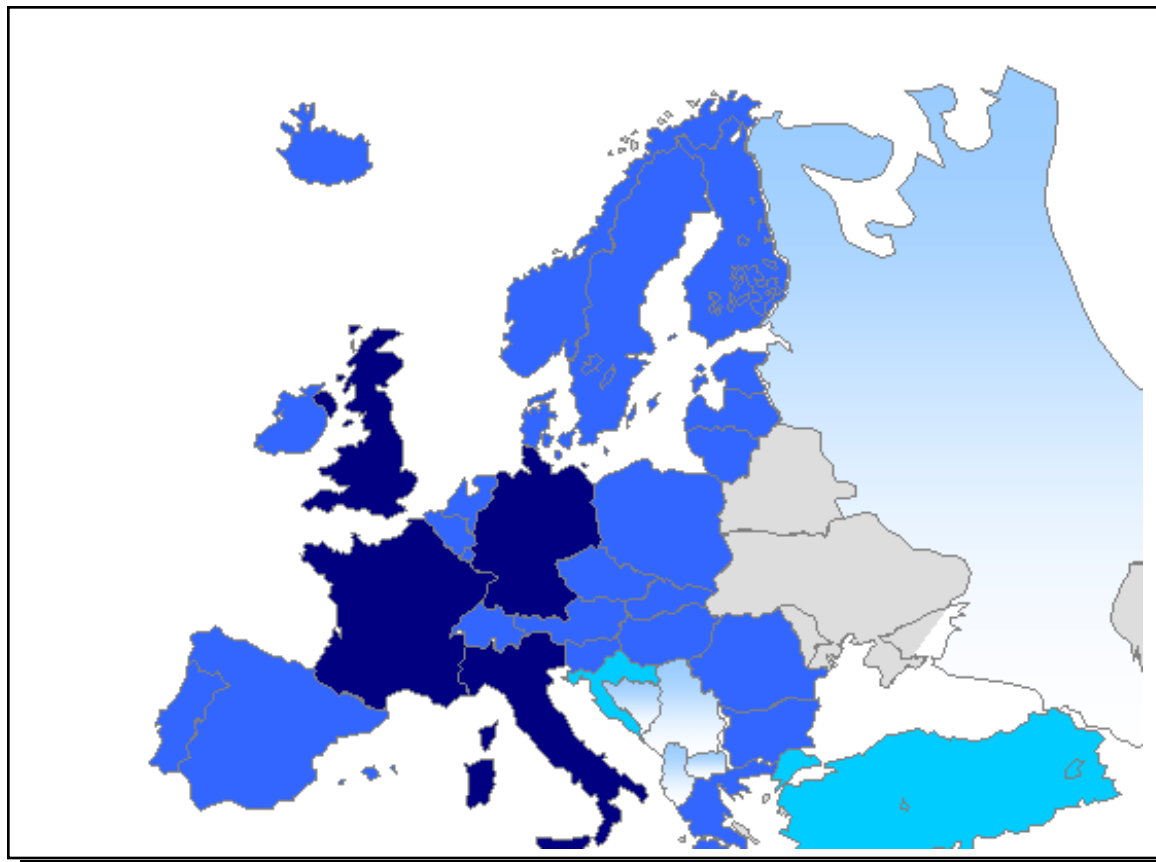
TABLE 1. Summary of the action lines introduced in the construction of the EHEA

| | |
|------------------------|---|
| PRAGUE 2001 | To emphasised as important elements of the EHEA: <ul style="list-style-type: none">• lifelong learning• involvement of Higher Education Institutions and students• Promoting the attractiveness of the European Higher Education Area |
| BERLIN 2003 | Three intermediate priorities for the next two years: <ul style="list-style-type: none">• quality assurance,• the implementation of the two cycles systems by 2005, and• the recognition of degrees and periods of studies.• Doctoral studies and the synergy between the EHEA and ERA |

During the Bologna Process new countries were included to the European Higher Education Area. At the moment, the emerging EHEA consists of 40 countries (figure 1).

Norway will host the next Ministerial Conference in May 2005 in Bergen.

FIGURE 1. Countries included on the European Higher Education Area (color-coded geographical areas indicates order of participation)



1.1.- ACCION LINES OF THE EUROPEAN HIGHER EDUCATION AREA

1.1.1.- TO ADOPT A SYSTEM OF COMPARABLE DEGREES . One of the most important objectives of the Bologna process is the establishment of readable and comparable degrees. To adopt a system of easily readable and comparable degrees, facilitates transparency in the educational structures and further innovation through communication of experience and identification of good practice. The transparency of qualifications and skills is to be improved through the European

Curriculum and providing detailed information on the curricula and their relevance towards a degree, through the implementation of the Diploma Supplement.

As defined in the Bologna Declaration, the study structure of the European Higher Education Area should essentially be characterised by two cycles – undergraduate and graduate:

- UNDERGRADUATE STUDIES (BACHELOR'S DEGREE) should be professionally oriented, and therefore should provide university training which brings together basic general knowledge, transversal abilities related to the integral training of the student, and knowledge specific to professional orientation which allows degree holders to more easily access the labour market.
- GRADUATE STUDIES (MASTER'S AND DOCTORAL DEGREE) should be academic, professional and research specialisation in a specific field of scientific, technical, humanistic or artistic knowledge, organised in official postgraduate programs.

1.1.1.1.- DIPLOMA SUPPLEMENT

The European Commission, the Council of Europe and UNESCO developed the Diploma Supplement in order to facilitate academic and professional recognition of qualifications (diplomas, degrees, certificates etc.).

The Diploma Supplement is a document attached to a Higher Education Diploma that:

- Provides a standardised description of the nature, level, context, content and status of the studies that were pursued and successfully completed by the graduate. Information is described in the respective national language and in English language.
- Provides additional information on the National Higher Education System, in order to fit the qualification into the relevant educational context.
- Facilitates international academic and professional recognition of qualifications and improves international transparency .

1.1.2.- TO ADOPT AN EUROPEAN CREDIT TRANSFER SYSTEM

(ECTS). ECTS was introduced within the framework of Erasmus programme (1989-1996), now part of the Socrates Programme. It has been tested over a period of 6 years in a pilot scheme involving 145 Higher Education institutions in all EU Member States and EEA countries, and is the only credit system which has been successfully tested and used across Europe.

A Credit System is a systematic way of describing an educational programme by attaching credits to its components. The definition of credits in higher education systems may be based on different parameters, such as student workload, learning outcomes and contact hours.

ECTS, European Credit Transfer System is a credit system, which provides a way of measuring and comparing learning achievements, and transferring them from one institution to another. As an effective instrument for creating curricular transparency and facilitating academic recognition the ECTS system supports European-wide mobility. The system facilitated the recognition of periods of study abroad and thus enhanced the quality and volume of student mobility in Europe.

ECTS is based on the convention that 60 credits measure the workload of a full-time student during one academic year. The student workload of a full-time study programme in Europe amounts in most cases to 36/40 weeks per year and in those cases one credit stands for 24 to 30 working hours. Workload refers to the notional time an average learner might expect to complete the required learning outcomes. The allocation of ECTS credits is based on the official length of a study programme cycle. The total workload necessary to obtain a first cycle degree lasting officially three or four years is expressed as 180 or 240 credits.

ECTS makes study programmes easy to read and compare for all students, local and foreign. ECTS facilitates mobility and academic recognition. ECTS helps universities to organise and revise their study programmes. ECTS can be used across a variety of programmes and modes of delivery. ECTS makes European higher education more attractive for students from other continents.

Recently ECTS is developing into an accumulation system to be implemented at institutional, regional, national and European level. (European Credit Transfer and Accumulation System).

1.1.3.- TO PROMOTE EUROPEAN CO-OPERATION IN QUALITY ASSURANCE.

A central goal of the “Bologna Process” is to define and observe Europe-wide quality standards in Higher Education. As a response to this Council initiative and the objectives of the Bologna Declaration, the European Network for Quality Assurance in Higher Education (ENQA) was established. Since 1999, ENQA has supplied information about proven practical experiences as well as the newest approaches and discussions in the field of quality assessment and quality assurance.

Accreditation and evaluation are the instruments to realize and observe quality standards. Both serve to assure quality when implementing new degree programmes and also to monitor existing ones. Accreditation, i. e. certification of a degree programme, will take place after review of the minimum standards for content and specialisation, the vocational relevance of the degree to be awarded and the coherence and consistency of the general conception of the degree programme. It will be awarded for a limited period of time within the frame of a transparent, formal and external peer review. Thus, the degree programme has to be reviewed after a certain time. The process of a peer review is steered by agencies which are also reviewed through regular external evaluation.

1.1.4.- TO PROMOTE EUROPEAN DIMENSION IN HIGHER EDUCATION. Within the framework of the EHEA, European Universities should become the most favoured destination for high level learning in the world. Closer co-operation between universities and other higher education institutions which can form so-called “associations” with each other, especially for the organisation of courses at Master’s level in the non-university higher education sector is improved. The activities related to this objective are carried out primarily by the universities themselves either through bilateral or multilateral agreements, or within the framework of more comprehensive programs, such as the EUA Joint Master’s Project.

Researchers from the European university association (EUA) are currently seeking to define a model for European Masters courses. They are addressing issues such as what ‘European’ is to mean in this context, what type of curriculum integration should take place, and what recognition arrangements would be implemented.

The Erasmus Mundus programme is a co-operation and mobility programme in the field of higher education. The programme is intended to strengthen European co-operation and international links in higher education by supporting high-quality European Masters Courses, by enabling students and visiting scholars from around the world to engage in postgraduate study at European universities, as well as by encouraging the outgoing mobility of European students and scholars towards third-countries.

The European Research Area (ERA) shall promote a common use of scientific resources, create jobs on a long-term basis, stimulate competition in Europe and establish synergies with the proposed European Higher Education Area.

2.- THE SPANISH UNIVERSITY AND THE BOLOGNA PROCESS: CURRENT SITUATION

The monitoring, development and coordination of activities in Spain related to the Bologna Process are carried out by the State Secretary for Education and Universities and the Department of Education and Science (Ministerio de Educación y Ciencia), which has set up a committee in which experts and representatives of the institutions involved in the process participate, as well as those ministers responsible for university policies. Inspiration for the implementation of the commitments and policies derived from Bologna Process can be found on the guidelines set out by the Organic Law on Universities on December 21, 2001 (Ley Orgánica de Universidades, LOU).

Based on the initial commitments of the Bologna Process and of the legal obligations established by the Organic Law on Universities, a Framework Document was drawn up in February 2003 regarding the Integration of the Spanish University System within the European Higher Education Area (Documento Marco del Ministerio de Educación para la Convergencia Europea en España).

The document includes a catalogue of specific measures to be introduced for the development and implementation of the Bologna Process in Spain and provides for four special fields of action:

- Degree Structure
- European Credit System
- European Degree Supplement
- Quality Assurance

2.1.- DEGREE STRUCTURE

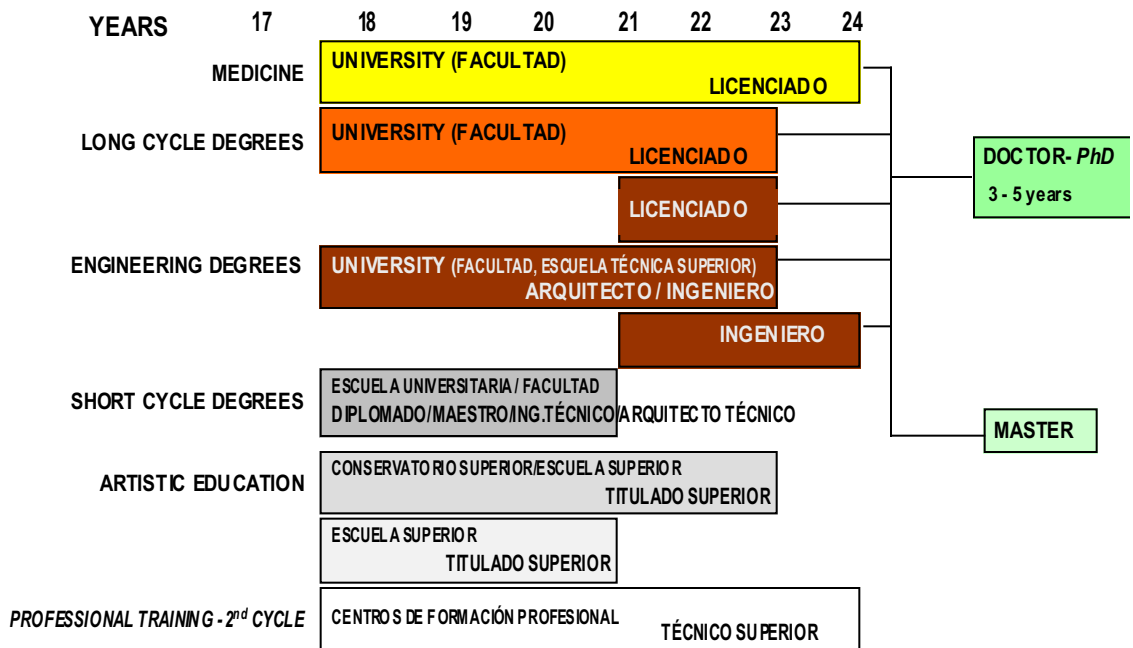
The Ministerio de Educación y Ciencia has drawn up drafts of the Royal Decrees regarding the structure of university teaching and official level studies, as well as on official post-graduate university studies and the issue of official Master's and Doctorate degrees:

- UNDERGRADUATE STUDIES: Borrador de Proyecto de Real Decreto por el que se establece la estructura de las enseñanzas universitarias y se regulan los estudios universitarios oficiales de grado. 25 de septiembre de 2003.

- GRADUATE STUDIES: Borrador de Proyecto de Real Decreto por el que se establece la estructura de las enseñanzas universitarias y se regulan los estudios universitarios oficiales de Postgrado. 26 de septiembre de 2003.

The structure of university studies in cycles, provided for in the Organic Law on Universities is based both on a first cycle or level, which should lead to an undergraduate degree, and a second, graduate level, which should lead to a Master's or Doctorate degree (figure 2).

FIGURE 2. Information on the Spanish National Higher Education System



2.2.- EUROPEAN CREDIT SYSTEM: ESTABLISHMENT OF A CREDIT SYSTEM COMPARABLE TO THE EUROPEAN SYSTEM

The credit system was introduced in Spain following the university reform of 1983; credits were determined primarily by the number of teaching hours, including both theory and practice. Additionally, and given the relationship between the ECTS and student mobility programmes, in particular Erasmus, and the important participation of Spanish Universities in this programme, the concept of credits is well known, as well as their usefulness and value for the automatic recognition of scholars in terms of level, quality and relevance.

One of the objectives of the Organic Law on Universities is the adoption of the European Credit System by Spanish Universities. The Royal Decree establishing the use of the European Credit System and the Official Grading System for University Degrees valid throughout national territory, was approved on September 2003 (Real Decreto 1125/2003, de 5 de Septiembre, BOE 224, de 18 de Septiembre de 2003).

The Royal Decree establishes the definition of the European Credit as the unit of assessment of academic activity, including theoretical and practical teaching, as well as other supervised academic activities and the volume of work the student must carry out in order to reach these educational objectives. In Spain institutional grading system according ECTS grading scale is as follows:

TABLE 2. Spanish grading system according ECTS grading scale

| | | | |
|----------|--------------|-----------|--------------------|
| A | EXCELLENT | 10 | MATRICULA DE HONOR |
| B | VERY GOOD | 9 | SOBRESALIENTE |
| C | GOOD | 8-7 | NOTABLE |
| D | SATISFACTORY | 6 | APROBADO |
| E | SUFICIENT | 5 | APROBADO |
| F | FAIL | 4-3-2-1-0 | SUSPENSO |

According with the Royal Decree establishing the use of the European Credit System and the Official Grading System for University Degrees, in 2003 the General Secretary of Universities and Research (Secretaria General de Universidades e Investigación) of the Secretary of Education and Sciences of the Andalusian Government (Consejería de Educación y Ciencia) in collaboration with the Andalusian

Committee for the European Higher Education Area (Comisión Andaluza para la implantación del Espacio Europeo de Educación Superior) set up a Pilot Project to introduce the European Credit Transfer System in the Andalusian Universities by academic year 2004-2005.

2.3.- EUROPEAN DEGREE / DIPLOMA SUPPLEMENT

The Royal Decree establishing the implementation of the European Degree Supplement was approved on August 2003, (Real Decreto 1044/2003, de 1 de Agosto, BOE 218, de 11 de Septiembre de 2003), as well as the procedure for its issue by Universities. The regulatory text provides for:

- The issue of the supplement to valid official degrees throughout national territory (with the exception of diplomas or degrees issued by the Universities themselves or in collaboration with non-university institutions).
- The content of the European degree supplement (student data, degree information, information regarding degree level, content and results obtained, the purpose of each degree, additional information, certification of the supplement, and information regarding the national system of higher education).

Information include in the Diploma Supplement is organised in eight sections covering different type of information (table 3).

TABLE 3. Information included in the Diploma Supplement

| DIPLOMA SUPPLEMENT: basic INFORMATION |
|---|
| 1.- INFORMATION IDENTIFYING THE HOLDER OF THE QUALIFICATION |
| 1.1 Family name (s)) |
| 1.2 Given name (s)) |
| 1.3 (Date of birth)(day/month/year |
| 1.4 Student identification number or code |

TABLE 3. Information included in the Diploma Supplement

| |
|---|
| <p>2- INFORMATION IDENTIFYING THE QUALIFICATION</p> <p>2.1.- Name of qualification and, if applicable, title conferred (in original language):</p> <ul style="list-style-type: none">• Studies• Title conferred• (state recognised) <p>2.2.- Main field(s) of study for the qualification)</p> <p>2.3.- Name and status of awarding institution (in original language):</p> <p>2.4.- Name and status of institution (if different from 2.3) administering studies (in original language):</p> <p>2.5.- Language(s) of instruction/examination: Spanish and/or</p> |
| <p>3. INFORMATION ON THE LEVEL OF THE QUALIFICATION</p> <p>3.1.- Level of qualification</p> <p>3.2.- Official length of programme</p> <p>The official length of the programme is..... courses of weeks each (..... hours in total) organised as follows:</p> <p>..... contact hours, devoted to lectures, practical work, specialised seminars, etc.</p> <p>..... non attendance hours, devoted to student work in his own,</p> <p>The estimate of student work (including the exam and the time It takes the student to prepare them).....</p> <p>3.3.- Access requirements(s)</p> |

TABLE 3. Information included in the Diploma Supplement

| |
|--|
| <p>4. INFORMATION ON THE CONTENTS AND RESULTS GAINED</p> <p>4.1.- Mode of study:</p> <ul style="list-style-type: none"> • Attendance (lectures, practical work, seminars, etc.) • Free <p>4.2 Programme requirements</p> <p>The programme must complete hours work, which sep the following distribution:</p> <p>..... Core and compulsory subjects (..... hours)</p> <p>..... Optional / elective subjects (.... hours)</p> <p>..... Free choice subjects / credits (... hours)</p> <p>4.3.- Programme details (e.g. modules or units studied) and the individual grade/marks/credits obtained:</p> <ul style="list-style-type: none"> • Core and compulsory subjects (subject; contact hours, non-contact hours mark, year, comments) • Optional / elective subjects (.... hours) • Free choice subjects / credits (... hours) • Subjects taken in other university (Erasmus-Socrates equivalence) <p>4.4.- Grading scheme and, if available, grade distribution guidance</p> <p>4.5.- Overall classification of the qualification (in original language):</p> <ul style="list-style-type: none"> • Global mark obtained in the degree |
| <p>5.- INFORMATION ON THE FUNCTION OF THE QUALIFICATION</p> <p>5.1.- Access to further study</p> <ul style="list-style-type: none"> • Access to Advanced Studies Diploma, Doctor Degree, Master and other non-official Postgraduate Studies <p>5.2.- Professional status (if applicable)</p> |
| <p>6.- ADDITIONAL INFORMATION</p> <p>General information about the University System of the country, the University, etc.</p> |
| <p>7.- CERTIFICATION OF THE SUPPLEMENT</p> <p>7.1.- Date</p> <p>7.2.- Signature</p> <p>7.3.- Capacity</p> <p>7.4.- Official stamp or seal</p> |

2.4.- QUALITY ASSURANCE

The Organic Law on Universities of 2001 dedicates Section V, to evaluation and certification, establishing as its primary objectives:

- the measurement of public service achievement in university education,
- the justification to society of university actions, transparency, comparison, cooperation and competitiveness of universities in both the domestic and international spheres,
- the improvement of teaching and research activities and of university management, the availability of information to Public Administrations for decision making, and
- availability of information to the general public in order to promote excellence and the mobility of students and teachers.

With the purpose of carrying out the above-mentioned activities the Law provided for the creation of ANECA, the National Evaluation, Certification and Authorisation Agency.

3.- MUSIC THERAPY TRAINING IN SPAIN WITHIN THE EUROPEAN HIGHER EDUCATION SYSTEM: METHOD AND AIMS

The purpose of the study is to describe and analyse systematically the present status of Music Therapy at the University in Spain presenting an evaluation of Private and University Masters and Postgraduate Training Programmes of Music Therapy in Spain, including information about Music Therapy Optional Subjects offer in undergraduate training programmes in the areas of Health Science (Nursing, Physiotherapy, Logopedics, Occupational Therapy), and Social Science (Special Education Teacher, Musical Education Teacher, Hearing and Language Disability Teacher).

Two matrix of data collection were designed in order to collect and organised information available through Internet search of Web Sites of Spanish Universities, telephone and personal interviews to university teachers and coordinators of Music Therapy University Training Programmes. Curriculum analysis, descriptive analysis and data triangulation with the action lines of Bologna Process are used to analyse, to describe and to discuss information collected.

3.1.- MUSIC THERAPY IN SPAIN: CURRENT SITUATION

Music Therapy in Spain is still a professional activity in the preliminary stages of establishing itself as a discipline and an officially recognised profession. Over the

past three decades most initiatives related to Music Therapy have been developed in an informal and non-official manner, in public or private institutions.

During the nineties, there was an increasing interest in Music Therapy both as discipline and as profession. The interest in music therapy training growth and Music Therapy Seminars and Introductory Workshops have been held in Universities (Universidad de Cádiz, Universidad de Barcelona, UNED, Universidad de Valencia, Universidad Jaume I, Universidad Blanquerna), Private Institutes (Centro de Investigación Musicoterapéutica, Música Arte y Proceso) and/or organised by Music Therapy Associations. Simultaneously, different music therapy training programs were offered by Universities and Private Institutes. As consequence of the interest in the field of music therapy and the need to establish a music therapy professional community, many Music Therapy Associations were founded in Spain in the latest nineties and in the beginning of the XXI Century.

Nowadays there is a growing demand of music therapist for the fields of Special Education, Geriatric Music Therapy, Neurological rehabilitation, Psychiatric and Medical Music Therapy. Although there are a lot of interest about music therapy as profession and in music therapy training, nowadays Music Therapy in Spain is not recognised as a profession by the government, neither as an official university degree¹.

3.2.- MUSIC THERAPY AT THE UNIVERSITY: AN OVERVIEW

There are sixty-nine Universities in Spain (Public and Private). The structure of university studies in cycles, provided for in the Organic Law on Universities, is based both on a first cycle or level, which should lead to an undergraduate degree, and a second, graduate level, which should lead to a Master's or Doctorate degree. University studies in Spain may be grouped into five branches: Humanities; Experimental Science, Health Science; Social and Legal Science; and Technical Education. Each branch may comprise, according to the case, first cycle; first and second cycle; second cycle only; and third cycle doctoral education.

During the nineties, the interest in music therapy training growth and Music Therapy Seminars, Workshops and Music Therapy training programs have been held

1. An extended report about Music Therapy in Spain was offered by the author in an article recently published (Sabbatella, 2004).

different Universities. The present status of Music Therapy at the University in Spain includes:

- Postgraduate Music Therapy Training Programs offered by Public or Private Universities
- Music Therapy Optional / Elective Subjects offered within official undergraduate universities degrees
- Introductory courses, Summer courses, seminars and workshops

There are not Doctoral Programmes in Music Therapy (PhD) in Spain.

3.2.1.- MUSIC THERAPY TRAINING PROGRAMMES. In Spain Music Therapy Training Programmes, - at Master or Post-Graduate Level-, are offered both by Private Institutions (since 1986) and Universities (since 1992).

From and historical perspective, the first Postgraduate Training Course in Music Therapy were offered by private institutions (Centro de Investigación Musicoterapéutica de Bilbao y en la Escuela de Musicoterapia y Técnicas Grupales de Vitoria-Gasteiz) during the eighties. In 1992, the first University Music Therapy Program was offered at the University of Barcelona and led by Serafina Poch.

During the nineties different Music Therapy Programs were organised both in private and public universities with different level (postgraduate /master) (table 4).

TABLE 4. Music Therapy Training Courses in Spain (May, 2004)

| MUSIC THERAPY TRAINING COURSES IN SPAIN | | |
|---|---|--|
| PUBLIC UNIVERSITIES | PRIVATE UNIVERSITIES | PRIVATE INSTITUTES |
| Universidad Autónoma de Madrid Universidad de Barcelona Universidad de Cádiz Universidad Nacional de Educación a Distancia | Universidad Católica de San Antonio Universidad Pontificia de Salamanca Universidad Ramon Llull | Centro de Investigación Musicoterapéutica Instituto Música, Arte y Proceso Musitando Fundación Mayeuisis ISEP ICSE |

According with the category and number of institutions that offer Music Therapy training courses in Spain Information collected shows that :

- Four Public Universities offered Music Therapy Training at Postgraduate or Master Level
- Three Private Universities offered Music Therapy Training at Postgraduate or Master Level
- Six Private Institutions offered Music Therapy Training

In order to describe the current situation of Music Therapy training at University level, a matrix for data collection was designed covering a wide range of information in different areas:

- Name of the University
- Level of Qualification of the Music Therapy Studies offered
- Starting Date of Programmes
- Recognition
- Entry requirements
- Official length of the Programme
- Curriculum /Programme
- Training programme coordinator (professional standing)
- Number of Music Therapists involved on the training – Guest teachers
- Areas of Clinical work

Data collected are presented in table 5.

TABLE 5.

MATRIX FOR DATA COLLECTION

| MATRIX FOR DATA COLLECTION | | | | | | |
|----------------------------|---------------|--------|------------|--------------|-------|------------------------|
| UNIVERSITY | QUALIFICATION | length | CURRICULUM | COORDI-NATOR | Nº MT | areas of clinical work |

TABLE 5.

| | | | | | | |
|---|--|----------------------------------|---|---|---|--|
| UNIVERSITAT DE VALÈNCIA (Valencia) | Postgraduate Curso Superior de Formación en MT (2000) | 2 years 1025 hours 102 cr. | Music Music Education Music Therapy Music Psychology Practicum Thesis | University Teacher (Psychology) Consultant MT | 3 | MT in Education Psychiatric MT Medical MT |
| UNIVERSITAT DE BARCELONA (Barcelona) | Postgraduate Curso de Postgrado Master Master en MT (1992/2001) | 2 years 504 hours 50 cr. | Music Music Psychology Health Sciences Music Therapy Practicum (6 m.) Thesis | University Teacher (Medicine) Consultant MT | 6 | MT in Education Psychiatric MT Medical MT MT in physical rehabilitation Geriatric MT |
| UNIVERSITAT DE VALÈNCIA (Valencia) | Postgraduate Curso de Experto Universitario en MT Master Master Universitario en MT (2000) | 2 years 550 hours 55 cr. | Music Music Education Music Psychology Music Therapy Health Sciences Practicum (3 m.) Supervision Thesis | University Teacher (Music-MT) | 8 | MT in Education Psychiatric MT Medical MT MT in Neurological rehabilitation Geriatric MT |
| UNIVERSITAT DE VALÈNCIA (Valencia) | Postgraduate Curso de Especialista Universitario en MT (2003) | 2 years 430 hours 43 cr. | Music Body Movement Music Therapy Psychology Practicum Thesis | University Teacher (Medicine) Consultant MT | 3 | MT in Education Psychiatric MT MT in rehabilitation |

TABLE 5.

| | | | | | | |
|--|--|---------------------------------|---|--|---|---|
| PONTIFICIA DE SALAMANCA Private University, Salamanca) | Postgraduate Especialista Universitario en MT Master Master Universitario en MT (2001) | 2 years 970 hours 97 cr. | Music Music Education Music Therapy Psychology Supervision Practicum Thesis | University Teacher (Music-MT) | 4 | Focus on education but introductory to other areas |
| UNIVERSIDAD NACIONAL DE EDUCACIÓN A DISTANCIA Public University, Madrid) | Postgraduate Curso de Formación del Profesorado: Música y Salud: Introducción a la MT (1996) | One year 150 hours 15 cr. | Music Education Health Sciences Music Therapy Practicum Thesis | University Teacher (Music Education -MT) | 1 | Focus on education |
| RAMON LLULL Private University, Barcelona) | Postgraduate Especialista Universitario en MT Master Master Universitario en MT (1996) | 2 years 600 hours 60 cr. | Music Music Education Music Psychology Music Therapy Clinical Work Practicum Thesis | University Teacher (Psychology-MT) | 4 | Medical MT MT in Education Psychiatric MT Geriatric MT |

3.2.1.1.- MUSIC THERAPY TRAINING PROGRAMMES: RESULTS

A.- LEVEL OF QUALIFICATION OF MUSIC THERAPY STUDIES OFFERED

Four Universities offer Double Music Therapy Degrees, both at Postgraduate and Master Level (Barcelona, Cádiz, Pontificia de Salamanca, Ramon Llul):

- POSTGRADUATE LEVEL, for students with a short degree: Diplomatura in the branches of Health Science (Nursing, Physiotherapy, Speech Therapy, Occupational Therapy), Social Science (Special Education Teacher, Music Education Teacher, Hearing and Language Disabilities Teacher), or
- MASTER LEVEL , for students with a long degree (Bachelor in the branches of Health Science (Medicine, Psychology), Humanities (History, Musicology), Art (Music, Dance).

Three Universities offer a Degree at Postgraduate Level, for students with a short degree (Autónoma de Madrid, Católica de San Antonio, UNED): Diplomatura in the branches of Health Science (Nursing, Physiotherapy, Speech Therapy, Occupational Therapy), Social Science (Special Education Teacher, Music Education Teacher, Hearing and Language Disabilities Teacher). Students with a long degree (Bachelor) are also accepted.

B.- STARTING DATE OF PROGRAMMES

The first University that started a training programme in Music Therapy was the University of Barcelona in 1992. This university stopped the programme and it was offered, in 1996 at the private University Ramon Lull. During year 2000 and 2001 different public and private universities started to offer Music Therapy studies (see table 5).

C.- RECOGNITION

Music Therapy Training, at Postgraduate or Master level, are recognised as own Degrees offered by each University (Título Propio). According with the structure of University Studies in cycles provided by the Organic Law on Universities and the Bologna Process, Music Therapy studies in Spain are not official degrees included in the annual catalogue of Graduate Studies offered for Spanish Universities.

D.- ENTRY REQUIREMENTS

The general requirement to apply to University Music Therapy studies in Spain is usually the completion of an undergraduate degree at bachelor level (short or long bachelor degree Diplomatura-Licenciatura), or equivalent in the fields of Music, Education, Health Science, Social Science, Humanities and/or Art.

There are not unified criteria to assess students entry requirements. Most courses selected students on the basis of an interview and audition. Applicants for the studies have to pass an exam of musical skills and music performance, and to demonstrate personal qualities needed for music therapy practice. The assessment of these skills is made through personal interview, musical skills are tested using different assessment tools.

Most of the courses required English proficiency to the level of reading comprehension.

E.- OFICIAL LENGTH OF THE PROGRAMME

The training programmes cover two years of training, with a period of music therapy practicum, except for the training programme at the UNED (one year). Teaching hours, including both therapy and practice, range from 150 hours (UNED) to 1025 hours (Autónoma de Madrid).

Music Therapy training programmes offers teaching hours in Spanish credit system (10 hours of class-work = 1 credit), but this system is not equivalent with the European Credit Transfer System (ECTS). According to this the structure and length of the Music Therapist training programmes in Spain must be adapted in the future.

F.- CURRICULUM /PROGRAMMAE

There is a significant variety with regard to the architecture of Music Therapy training courses in Spain. The seven University training courses analysed are different in structure, duration, academic level and theoretical orientation. Although there is a dominant trend and it is possible to distinguish common objectives, tasks and areas of study among them, there are not unified criteria to define the core areas of study, subjects, skills and competences to become a professionally-qualified music therapy.

Curriculum analysis shows that programmes have common AREAS OF STUDY among them: Music, Music Therapy Theory, Clinical Practice (Health Sciences), Music Therapy Practicum and Supervision. These common areas of study covers different subjects, contents, number of contact and practical hours and didactic and experiential training in how music and the client-therapist relationship are used to promote health. There are large differences both in length and depth of study.

About OBJECTIVES, the programmes are designed to give students the ability to apply music therapy theory to practice on a broad range of clinical populations, theoretical orientations, practices and methods.

THEORETICAL ORIENTATION of the training programs do not concentrate on any single model or method, are eclectic. Music Therapy programmes in Spain give a wide picture of music therapy, its different schools, models and methods. The orientation of the studies are focus on the professional practice of Music Therapy as a primary objective of the programmes (not focus on research).

EXPERIENTIAL COMPONENTS of the programme are designed to sensitise students to the effects of the music on the therapy process and the self-experience of the music

therapy process on the student. Another important element is focus on give the students opportunities to explore and refine his/her own individual philosophy and style of working.

MUSIC THERAPY PRACTICUM (clinical field experiences) are an integral part of the music therapy curriculum. There are not too much music therapists working in Spain, so in some cities is not easy to find enough institutions to provide a wide range of clinical practicum options for students in the programmes.

G.- TRAINING PROGRAMME COORDINATOR (PROFESSIONAL STANDING)

The Spanish University System establish that Postgraduate and Masters Programmes must be coordinated by university teacher staff.

From a total of seven Music Therapy University training programmes only four are coordinated by university staff with training in the field of music therapy (UNED; Universidad Ramon Lull, Universidad Pontificia de Salamanca, Universidad de Cadiz).

The other three programmes are coordinated by university staff of related fields (psychology and medicine) that have an external consultant in the field of music therapy who acts as programme's coordinator (Universidad Autónoma de Madrid, Universidad de Barcelona, Universidad Católica de Murcia).

H.- NUMBER OF MUSIC THERAPISTS INVOLVED IN THE TRAINING – GUEST TEACHERS

The number of professionally-qualified music therapist involved in University training is diverse, and depends on the curriculum organisation of each university.

The academic background of the music therapists working and teaching in Spain is diverse: some of them are Music therapists with a University Degree or a Postgraduate Training at Master Level in Music Therapy obtained at a foreign university (Latin-America or USA); but most of them are professionals of other disciplines with a Postgraduate Training in Music Therapy obtained at Private Institutes during the nineties (instituto Musica, Arte y Proceso, Centro de Investigación en Musicoterapia de Bilbao).

Some training courses have foreign teachers (Universidad de Cádiz, Universidad Ramon Llul) and most of them invite teacher from other Spanish universities or

institutes to teach (Universidad de Cadiz, Barcelona, Pontificia de Salamanca, Católica de San Antonio, Ramon Llul).

Only five qualified-music therapists who have a PhD are involved in teaching music therapy at the University in Spain.

I.- AREAS OF CLINICAL WORK

University Music Therapy programmes are designed to give students the ability to apply music therapy on a broad range of clinical populations.

The client populations covered in training courses tended to be similar, in the fields of Music Therapy in Education, Psychiatric Music Therapy, Medical Music Therapy; Music Therapy in physical and neurological rehabilitation and Geriatric Music Therapy. Two of these courses (UNED and Pontificia de Salamanca) are more focus on Music Therapy in Education but introduce clinical practice in other areas.

Usually students choose one area of clinical work and client population for music therapy practicum

3.2.2.- MUSIC THERAPY OPTIONAL/ELECTIVE SUBJECTS OFFERED IN UNDERGRADUATE UNIVERSITIES DEGREES

Within the official studies recognized by the Spanish Government, Music Therapy is offered as a subject in different Universities Degrees. The positive point is that Music Therapy is included as a subject in different degrees and allows its promotion within the students of related professions to Music Therapy.

In order to describe the current situation of Music Therapy training at University level, a matrix for data collection was designed covering a wide range of information in different areas:

- University – Faculty – Department
- Degree
- Subject - Credits
- Teacher Staff

Data collected are presented in table 6.

TABLE 6. Optional subjects offered at University undergraduate studies in Spain during academic year 2003-2004

| UNIVERSITY | FACULTY | DEPARTMENT | DEGREE | SUBJECT | CR. |
|--------------------|-----------------------------------|--|---|--|-----|
| ALCALA DE HENARES | E. U. Cardenal Cisneros (College) | Expresión Musical, Plástica y Corporal | Hearing and Language Disabilities Teacher | Music Therapy | 4.5 |
| AUTONOMA DE MADRID | E. U. Lasalle (College) | Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy | 4.5 |
| | Teacher Training | Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy workshop for pupils with special needs education | 4.5 |
| BURGOS | Humanity and Education | Expresión Musical, Plástica y Corporal | Musical Education Teacher | Fundamentos de Musicoterapia | 5 |
| CÁDIZ | Sciences Education | Didáctica de la Educación Física, Plástica y Musical | Musical Education Teacher | Music Therapy in Music Education | 4.5 |
| | | | Hearing and Language Disabilities Teacher | Music Therapy in Hearing and Language Disabilities | 4.5 |
| | | | Special Education Teacher | Music Therapy in Special Education | 4.5 |
| CORDOBA | Sciences Education | Didáctica de la Expresión Musical, Plástica y Corporal | Musical Education Teacher | Music Therapy | 6 |
| | | | Special Education Teacher | Music Therapy | 6 |
| GRANADA | Sciences Education | Expresión Musical, Plástica y Corporal | Musical Education Teacher | Music Therapy | 4.5 |
| | | | Special Education Teacher | Music Therapy | 4.5 |

TABLE 6. Optional subjects offered at University undergraduate studies in Spain during academic year 2003-2004

| | | | | | |
|-------------------------|--------------------|--|---------------------------|-------------------------------|-----|
| HUELVA | Sciences Education | Expresión Musical, Plástica y Corporal Psychology | Musical Education Teacher | Music Therapy | 4.5 |
| | | | Special Education Teacher | Music Therapy | 4.5 |
| JAUME I | Sciences Education | Expresión Musical, Plástica y Corporal | Musical Education Teacher | Introduction to Music Therapy | 4.5 |
| LA CORUÑA | Health Science | Psychology | Occupational Therapy | Music Therapy | 4.5 |
| LA RIOJA | Education | Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy | 4.5 |
| LEON | Education | Expresión Musical, Plástica, Corporal, Dibujo y Educación Física y Deportiva | Musical Education Teacher | Music Therapy | 6 |
| | | | Special Education Teacher | Music Therapy | 6 |
| MALAGA | Sciences Education | Expresión Musical, Plástica y Corporal | Musical Education Teacher | Music Therapy | 6 |
| | | | Special Education Teacher | Music Therapy | 6 |
| MURCIA | Education | Expresión Musical, Plástica y Corporal | Musical Education Teacher | Music Therapy | 4.5 |
| SEVILLA | Sciences Education | Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy | 4.5 |
| PONTIFICIA DE SALAMANCA | Sciences Education | Education | Special Education Teacher | Music Therapy | 4.5 |

TABLE 6. Optional subjects offered at University undergraduate studies in Spain during academic year 2003-2004

| | | | | | |
|------------|--|--|------------------------------|---------------|-----|
| PAIS VASCO | E.U. Magisterio (Education College) | Didáctica de la Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy | 4.5 |
| VALENCIA | E. U. Magisterio (Education College) | Didáctica de la Expresión Musical, Plástica y Corporal | Special Education Teacher | Music Therapy | 4.5 |
| | | | Musical Education Teacher | Music Therapy | 4.5 |
| | E.U. Fisioterapia Physiotherapy | | Physiotherapist | Music Therapy | 4.5 |

From a total of 69 public and private universities, 17 offer Music Therapy subjects within undergraduate studies.

Two universities offer Music Therapy subjects at the Health Sciences College, Universidad de La Coruña, offering a subject in the degree of Occupational Therapy, and Universidad de Valencia, offering a Music Therapy subject in the degree of Physiotherapy.

The rest of the universities, 15, offer Music Therapy subjects at the Faculties of Education, within the degrees of Teacher Education, in the fields of Special Education Teacher and Musical Education Teacher. From 15 universities, 2, offer Music Therapy subject in the degree of Hearing and Language Disabilities Teacher (Alcalá de Henares and Cadiz)

Departments involved in the teaching are those related to Music and Music Education subject fields (Departamento de Expresión Musical, Plástica y Corporal). Only in the case of Universidad de La Coruña, the Department of Psychology is involved on music therapy teaching.

The subjects offer are generally called Music Therapy, in some cases the name of the subject vary according the degree where it is offered (eg. Music Therapy in Special Education, Music Therapy in Music Education, Music Therapy in Hearing and Language Disabilities).

The subjects offer are optional subjects covering 45-60 hours of teaching (4.5-6 Spanish credit system), display on one semester.

About qualification of the teacher staff involved not all of them are qualified-music therapists with clinical experience in music therapy. Most of them are teachers of the field of music or music education that attended introductory training course or summer course in music therapy. Only a few of them attend International, European and Latin American Music Therapy Congresses. About publications, some of them published some articles but on the general field of Music Therapy in Education, or Music Therapy History, not regarding clinical practice, theory or research of Music Therapy.

Data collection revealed that there are optional subjects offered related to the field of music therapy but not named as Music Therapy, for example:

- Music for students with learning disabilities: Universidad de Almeria
- Music in Special Education: Universidad de Granada
- Music for students with Special Needs Education: Universidad de Granada (Melilla)
- Music for handicapped children: Universidad de Málaga

4.- CONCLUSION

The main conclusion of the study is that there is a significant variety with regard to the architecture of Music Therapy training courses offered by Universities in Spain. The seven University training courses analysed are different in structure, duration, academic level and theoretical orientation. There are large differences both in length and depth of study.

Although there is a dominant trend in the curriculum and it is possible to distinguish common objectives, tasks and areas of study among them, there are not unified criteria to define the core areas of study, subjects, skills and competences to become a professionally-qualified music therapy.

According with the structure of University Studies in cycles provided by the Organic Law on Universities and the Bologna Process, Music Therapy studies in Spain are not official degrees included in the annual catalogue of Graduate Studies offered for Spanish Universities. Music Therapy at Postgraduate or Master level are recognised as own Degrees offered by each University (Título Propio). This situation promotes that too many private institutions offer short training courses in music therapy (100 hours) with not qualified music therapy teachers.

As Music Therapy training programmes are not official degrees its difficult to connect teaching and exchange of students with Erasmus-Socrates programme. Cooperation is only used for teacher mobility at the University of Cádiz and University Ramon Lull.

Music Therapy training programmes offers teaching hours in Spanish credit system. According with the Royal Decree establishing the use of the European Credit System and the Official Grading System for University Degrees, in 2003, the structure and length of the Music Therapist training programmes in Spain must be adapted in the future to ECTS system.

To establish unified criteria and standards for Music Therapy training that leads to an official Master in Music Therapy according the rules of EHEA requires the establishment of the syllabus according the action lines of the Bologna Process and the guidelines set out by the Organic Law on Universities (Ley Orgánica de Universidades, LOU):

- To adapt the architecture of the studies in order to unified the curriculum and delimitate core subjects and contents presenting the coursework of studies in European Credits Transfer System (ECTS) with the structure of an official Master Diploma (120ECTS).
- To establish an unified set of learning outcomes and competences for Music Therapy studies in order to implement the Diploma Supplement (although the Spanish University does not give diploma supplement for non official master).
- To prepare university and official documents for government recognition and national accreditation of the Spanish foreign agency ANECA (Agencia Nacional de Evaluación y Calidad Educativa), compulsory for official degrees/masters in Spain.

According the Bologna Process and the current status of Music Therapy Universities studies at Master or Postgraduate Level in Spain, music therapy studies will not be officially recognized by the government according the standards of the EHEA. A deep modification is needed in order to get it.

The insertion of the National University System in the Bologna Process is clearly an attractive element of Spanish centres in all Graduate and Postgraduate Degrees. A new perspective is coming in order to bring a Europe-wide convergence in Higher Education. Further internationalisation of universities and intensification of mobility will guarantee a wide access to university education and an increase in the quality of study offers. Within the perspective of the Erasmus Mundus Programme, the overseas promotion of the Spanish university system within the framework of

the European Higher education Area will, over the next few years, be considered a field for special pursuits in national policies on university cooperation with third countries and intensified university relations within the framework of the UEALC (European Union – Latin America – Caribbean Programme).

4.1.- IMPLICATIONS FOR MUSIC THERAPY TRAINING PROGRAMMES WITHIN THE EUROPEAN HIGHER EDUCATION AREA

The context of the Bologna-Prague-Berlin process has provoked an intense debate on the nature of educational structures, the role and the social dimension of Higher Education and the structure of the University Degrees in Europe.

There has been too much discussion in Europe about the potential for establishing a common standard for music therapy education. This has proven very difficult, given the wide variation in the length of the training courses – from a one year post-graduate study to five –year full-time studies- and the variation in the contents of the courses (Wigram, De Backer & Van Camp, 1999).

One of the most important objectives of the Bologna process is the establishment of readable and comparable degrees and the adoption of a two cycle system. The construction of an European Higher Education Area (EHEA) by 2010 could be an attractive element for Music Therapy studies in Europe in order to obtain official recognition of Music Therapy studies in the European Community².

Music Therapy training courses in Europe need to integrate themselves within the rules of the EHEA and define a model for European Masters courses in Music Therapy, with curriculum convergence and a set of professional competences that facilitate European and national government recognition. This proposal implies:

- To develop professional profiles and desired learning outcomes and competences in terms of generic competences and subject-related competences including skills, knowledge and content to become a professionally-qualified music therapy.
- To develop and exchange information in relation to the development of curricula in the selected areas, and develop a model of curriculum structure expressed in ECTS.

Within the framework of the EHEA, European Universities should become the most favoured destination for high level learning in the world. Closer co-operation

2. The European Music Therapy Confederation is working on it.

between universities, through International Programmes as Socrates–Erasmus or Erasmus Mundus could enhance the quality of Music Therapy Training and Research and to promote intercultural understanding through co-operation with third-countries.

The European University System is in a period of change that could be described as historical. It is time that Music Therapy can reach the academic and professional status that is deserved. A great work is needed to get it.

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LINKS

Accreditation: <http://www.accreditation-council.de/>

Diploma supplement:

europa.eu.int/comm/education/policies/rec_qual/recognition/diploma_en.html

Implementation of the Diploma supplement:

www.cepes.ro/hed/recogn/groups/diploma/Default.htm

European Centre for Higher Education: www.cepes.ro/

European Research Area: europa.eu.int/comm/research/era/index_en.html

European Credit Transfer System: http://europa.eu.int/comm/education/bruges/index_en.html

European University Association (EUA): www.eua.be/eua/

European Association of Institutions in Higher Education: www.eurashe.be/

European Network for Quality Assurance in Higher Education (ENQA): <http://www.enqa.net/>

ERASMUS: Thematic Network Projects: <http://europe.eu.int/comm/education/socrates/tnp/index.html>

International Network for Quality Assurance Agencies in Higher Education (INQAAHE): <http://www.inqaahe.nl/>

Lifelong Learning: http://europa.eu.int/comm/education/index_en.html

Network of Universities from the Capitals of Europe (UNICA): www.ulb.ac.be/unica/

Programa de Convergencia Europea: www.aneca.es/modal_eval/prog_conver.htm

Recognition of Diplomas in the European Union:

europa.eu.int/comm/education/policies/rec_qual/recognition/in_en.html

The Europe of knowledge 2020. A vision for university based-research and innovation. Liege, 25-28 April, 2004. http://europa.eu.int/comm/research/conferences/2004/univ/results_en.html

Tuning Project: <http://odur.let.rug.nl/TuningProject/index.htm>;
www.relint.deusto.es/TUNINGProject/index.htm

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CHAPTER 48

*The effectiveness of music therapy
approach focused on 'subjective
tempo'*

Saji' Nobuko & Sugai' Kuniaki

**Editors note: Check for the html
version with all video and audio files on
MusicTherapyToday.com (November
2005)**

Abstract

In this study, we confirmed that people with severe senile dementia, the disease of irreversible deterioration, still possess ability to learn, and the approaches focused on subjective tempo and the continuous music therapy sessions could enable them to learn new songs. Subjective tempo, first defined by Perilli in 1993, is the tempo in which each individual can respond spontaneously to music, such as singing, playing drums, clapping hands or performing in other ways.

For approximately 4 years, we examined 70 subjects (the mean ages: 82.74 ± 1.19 years, the mean MMSE: 14.6 ± 5.7), who were clients in our weekly music therapy group sessions and individual sessions. In every session, first, we identified the subjective tempo of each subjects through his/her responses to a well-known familiar song, then played an unfamiliar song to each individuals with their just identified subjective tempo and observed the process of learning this particular song.

The results demonstrated that 1) severely demented clients have potential to learn a new song, although more time was required than slightly demented clients, and that 2) the approach using subjective tempo is effective to support and maintain learning ability of elderly people with dementia.

1. Introduction

1.1. MUSIC THERAPY RESEARCH TO DEMENTED CLIENTS

The latest findings from medical science, using noninvasive examinations of brain-function such as MRI and CT scan, have shown that performing cognitive tasks such as numerical calculation or reading out loud can have an effect on the cognitive abilities of the elderly people. These visually measurable examinations indicate that the above behaviors, especially reading out and singing would activate the frontal and back channels of brain map (Kawashima 2002).

Since 1998, we have held group and individual sessions for people suffering from senile dementia in Japan and examined the efficacy of music therapy practice through physiological and behavioral evaluations (Saji, Sugai & Saji, 2004a). Previously, we have reported the first physiological evaluations of our research in the 10th world congress of music therapy at Oxford (Saji, Ueno & Sugai, 2002, in press) and the International Musicological Congress at Shizuoka (Saji, Sugai & Ueno, 2004b). These reports demonstrated that severely demented subjects showed significant differences at the alpha-2 bands only on right channels while they lis-

tened to familiar songs ($<.05$) and familiar songs played with subjective tempo ($<.01$). We considered familiar songs and subjective tempo produced a big active change in the EEGs of severely demented subjects. EEG analysis of non-severely demented subjects also showed significant differences in the theta-1 and theta-2 bands on the right and left channels while they listened to familiar songs ($<.05$) and familiar songs played with subjective tempo ($<.05$) and non-subjective tempo ($<.05$). We considered that non-severely demented subjects had ability to adjust themselves to familiar songs played with both subjective tempo and non-subjective tempo, so their EEGs showed active changes in the right and left channels. Therefore music therapy sessions with subjective tempo are effective for subjects with dementia, particularly for those with severe dementia, and we also confirmed that EEG analysis is useful to assess the efficacy of music therapy for subjects suffering from dementia (Saji, Sugai & Ueno, 2004b).

Many music therapy researches (Aldridge 2000, Brotons 1996, Clair 1991 and 1996, Clair & Berstein 1990a and 1990b, Hanser 1990 and others) based on behavioral evaluation of people with Alzheimer's disease have pointed out that "musical functions may be retained longer than speech functions" (Aldridge, 1996) and that "music therapy is a viable approach to promote meaningful and purposeful activities even into the last stages of dementias" (Hanser & Clair 1995, p. 346). While we examined the processes of acquisition and deterioration of musical skills of demented clients in the nursing home, we also found they had potential to learn a new song. Sugai (1994) hypothesized that the learning process of human linguistic ability was linked to the information system of the human brain. He examined the process through the early phonetic and linguistic behavior of children with developmental delays, examining their behavior when they sang popular Japanese nursery songs. His process of the early development of speech behavior was from auditory and visual to tactile reception

Today, we will present the second behavioral evaluation from the same research focused on 'subjective tempo'. Examining this process in which demented clients acquired music is important in informing treatment to support improvement in clients' quality of life.

1.2. THE TEMPO IN MUSIC THERAPY

We found the 'tempo' is extremely important to communicate with demented clients in music therapy sessions, particularly with those who are severely demented.

Since we first began working at a nursing home for elderly people with dementia, including Alzheimer's disease, cerebral infarction, Parkinson's disease and others, we were interested in reactions of clients to music. When familiar music was

played, every client immediately made relaxed expressions and released tension from their bodies. Soon, they began to show responses to the music. Some of them moved their mouths, some of them tapped their hands in time with the music, and others nodded slowly. However, very few of them showed different reactions. They either became agitated and frustrated or made no responses as if they heard nothing. In such cases, we assumed that there was a gap between the tempo we played and their subjective tempo. In another words, we understood that the tempo of the given music was beyond the capacity of which they could understand and make responses to. On the other hand, we understood that for those who showed musical responses, the tempo of the music was closely matched with their subjective tempo. In this way, we assumed that the receivable tempo could be a crucial factor, which allowed the clients to make musical responses.

1.3. GROUP SESSIONS

Japanese elderly people generally enjoy singing and playing familiar music together in groups but show strong resistance to sing or play alone. Maybe it is because they are very shy and feel embarrassed to perform in front of someone. However, playing together seems to bring joy to them and enables them to relax. Aldridge stated group music therapy was “generally used to expand socialization and communication skills, with the intention of reducing problems of social isolation and withdrawal, to encourage clients to interact purposefully with others, assist in expressing and communicating feelings and ideas, and to stimulate cognitive processes, thereby sharpening problem-solving skills ” (Aldridge 1996, p.195). In our group sessions, however, there were some clients who need special support in a group session. Some of them were in the severe stages of their illness and their subjective tempos were remarkably slower than others. Some of them wandered around during the whole session and could not sit together with others. Then our individual sessions were started for them.

1.4. WHAT IS ‘SUBJECTIVE TEMPO’?

The term ‘Subjective Tempo’, first stated by Perilli in 1995, however, has also been called in other ways. In 1933, psychologist Frischeisen-Koehler used the term ‘personal tempo’ and, in 1951, Mischima, who was also a psychologist, used the term ‘mental tempo. Both psychologists examined the subjective tempo from natural spontaneous finger tapping of healthy students. Stern (1985) and Fraisse (1982) also talk about ‘spontaneous tempo’. Based on this ‘spontaneous tempo’, Perilli assumed that subjective tempo might change or vary between people and also within each person, according to emotional and pathological states. She examined each tempo of natural spontaneous finger tapping of healthy students and adults with mental illness. From this research, Perilli concluded that the tempo of which

individuals spontaneously tapped are directly connected with their psychomotor, cognitive and emotional processes. In other words, this subjective tempo is the speed in which each individual could apprehend, register and understand incoming stimuli. Also, the subjective tempo is the speed in which each individual could react, plan and perform behavioral responses to stimuli (Perilli 1995, p.104).

1.5. THE DEFINITION OF 'SUBJECTIVE TEMPO'

We thought, however, the examination by finger tapping would not be suitable for clients with dementia because they had difficulties in understanding and following the instructions and also had poor physical functions. Therefore, we carefully examined the overall responses of every participant during the sessions and searched for each individual subjective tempo, the tempo that elicits smile or allows either spontaneous drum beating, hand clapping or singing. Through these observable responses, we concluded that it is the subjective tempo that enabled elderly people with dementia to listen, to understand, and to express themselves spontaneously. At the same time, these reactions indicate that the interpersonal communication had been formed between the clients and the therapist, who is the performer of the music. However, the identification of subjective tempo was done through observation and they were determined by the therapist's experience.

The purpose of this study is to examine the effectiveness of music therapy approach focusing on subjective tempo to elderly people with dementia.

2. Methods

2.1. DEMENTED CLIENTS

During 4 years of this research, 70 people (mean age: 82.74 ± 1.19 , mean MMSE: 14.6 ± 5.7), participated in our weekly music therapy group sessions and individual sessions. We classified these clients into two groups: The severely demented group, the group of those who were less than MMSE 8, and the non-severely demented group, the group of those with MMSE 11 to 23. Table 1 shows the attributes of the clients in severely and non-severely demented groups (mean \pm standard deviation).

TABLE 1. Severe group and non-severe group (2001)

| Groups | Numbers | Mean Age | Mean MMSE |
|------------|-----------|-------------|-------------|
| Severe | 36(12/24) | 84.06•}7.54 | 5•}3.27 |
| Non-severe | 34(9/25) | 81.62•}8.90 | 19.47•}5.39 |

2.2. SUBJECTIVE TEMPO

In every session, we identified and recorded the subjective tempo of each client through his/her response to the well-known familiar songs and examined each client’s behavioral change, which occurred over the four years.

In this research, we understood that when clients responded spontaneously to given music, it indicated that subjective tempo was closely connected with client’s current conditions. The therapist made a judgment whether the music was played in suitable tempo or not, through clients’ behaviors. If they responded to the given music by singing or tapping hands and other positive behaviors, the therapist considered that they could understand the music and respond to it. On the other hand, if they began to speak something unrelated to the song, stand-up and walk around, fall asleep or perform other passive behaviors, as if they heard nothing, the therapist considered that they could not understand the music and respond to it. Beside these, the therapist found the middle responses. Some of them seemed to be willing to respond to the music, but could not figure out how to respond. Even if the clients did not make any responses, or even if the therapist could not recognize any intention of making responses to the music from their behavior, it was important for the therapist to keep the musical contact with them. The therapist hoped and waited for them to respond spontaneously.

We reported previously that the mean subjective tempo of a familiar working song, ‘Saitaro-bushi’, in non-severely demented group rose above M.M.♩=80, but in severely demented group, the mean subjective tempo was kept under M.M.♩=80 (Saji & Muzuno, 2003). This study examined mainly subjective tempo of children’s songs or old Japanese school songs.

2.3. THE LEARNING SONG: THE UNFAMILIAR SONG

For the unfamiliar music, we chose a pop music kind of song, called ‘Present My Love’. This song was composed specially for this nursing home in 1998. So it was new for every body and truly an un-familiar music for clients. The words of the song expressed appreciation to nature and life and it was very touching for elderly

people, but the melody was complicated with many phrases with up beats, syncopations and jumping tones and others. The tempo was indicated in M.M. ♩=108 by the composer, but of course it was too fast for the all demented clients. We thought the song was unsuitable for music therapy sessions, but the director of this nursing home strongly requested us to play this song in the sessions. Reluctantly, from May 1998, we started to play it at the end of every session as an ending song. While the song was played, clients returned to their own rooms. We did not expect them to sing or play with this music, but only hoped that, one day, all the staffs and residents would become familiar to this song and be able to sing together on ceremonies.

FIGURE 1. Score of the new unfamiliar song, 'Present My Love'

Present My Love

Words: Mimiina Hoshino
Composition: Akira Yuyama

Cantabile (ca. ♩=108)

Copyright 1998 by Mimiina Hoshino & Akira Yuyama

Notes: This song is a new styled music. For examples 'a' in the score indicates the phrase beginning with up- beat, 'b' indicates syncopation rhythm and 'c'

2.4. THE STANDARD EVALUATION OF A LEARNING SONG

Unexpectedly, soon after we began to play this unfamiliar song, 'Present My Love', some clients requested for a score. Therefore, we thought that this song could be a good material to observe the process of learning of a new song. We played this song for approximately 4 years at the end of every session and observed the process of changes occurred in responses of each member. We classified them into three stages.

The first stage: The stage of Negative responses; this is the stage when clients showed no responses to music, or began to speak something unrelated to the song, or when he/she fell asleep. The second stage: The stage of Non-negative responses; this is the stage when the clients showed little reactions, such as looking at other members singing or the-therapist. The third stage: The stage of Positive responses. We subdivided this stage into two levels: when the clients moved mouths or heads with the music, we identified as they are in the first level. When the clients sang the song loudly or sang from the beginning to the end of the song, we identified as they are in the second level.

3. Results

3.1. RECORDED SUBJECTIVE TEMPOS

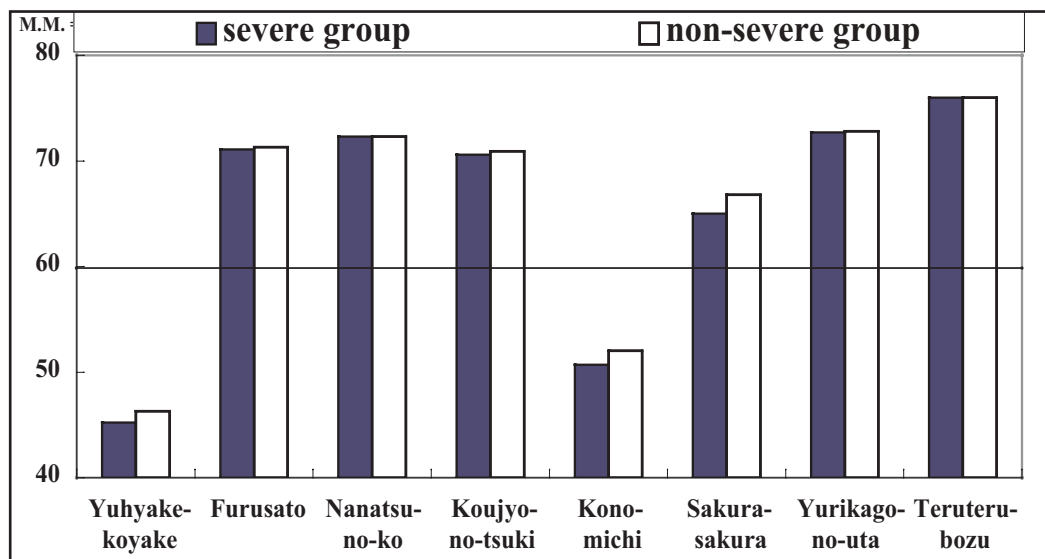
Subjective tempos of every individual were video recorded from 1998 to 2001. Before we played the new unfamiliar song, 'Present My Love' as an ending song, we played the familiar children's songs and old Japanese songs and identified the subjective tempos of each member from their singing, nodding head, tapping hands and others. Figure 1 shows the mean subjective tempos of their responses to the familiar songs in both severely demented group and non-severely demented group.

The mean subjective tempo of non-severely demented group was faster than that of severely demented group. Particularly in 'Yuhyake-koyake' (a children's song), 'Kono-michi' and 'Sakura-sakura' (old Japanese songs) the mean subjective tempos of non-severely demented group were clearly different from those of severely demented group. Other songs in Figure 1 showed close or same subjective tempos.

Mean subjective tempo of 'Yuhyake-koyake' (a children's song) and 'Kono-michi' (an old Japanese song) was under M.M.♩=60 in severely and non-severely

demented groups. On the other hand, mean subjective tempo of other songs were among M.M.♩ 60-80 similarly in both groups

FIGURE 2. Mean subjective tempo recorded in music therapy sessions



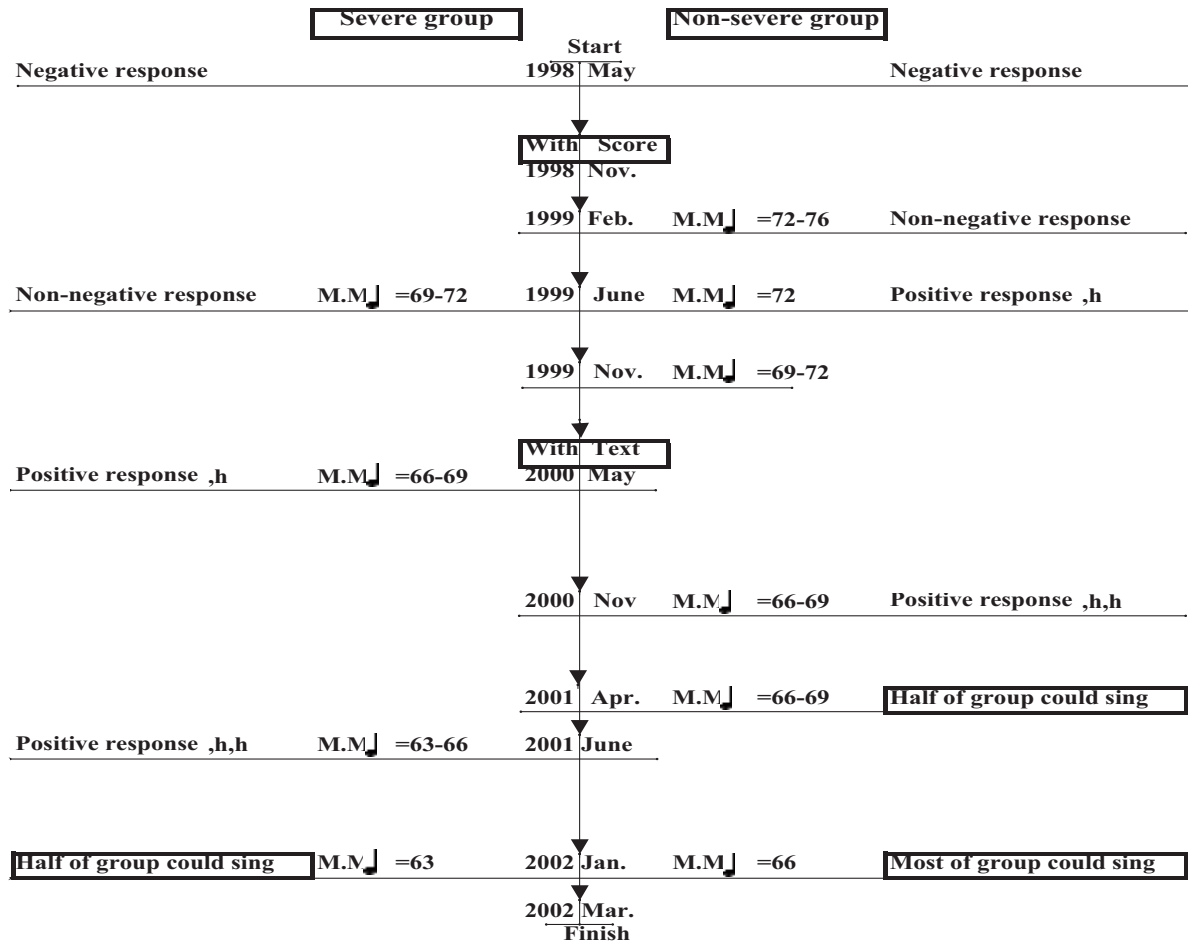
‘Severe group’ indicates severely demented group and ‘non-severe group’ indicates non-severely demented group. ‘MM =’ indicates M.M. (Metronome Marking)♩ equals.

3.2. LEARNING PROCESS OF A NEW UNFAMILIAR SONG.

Every session, the new unfamiliar song, ‘Present My Love’ was played with the subjective tempo, which was identified from familiar songs. I have noted the mean subjective tempo we played in each stage. The tempo of non-severely demented group on each stage was faster than those of severely demented group. For instance the tempo of the non-severely demented group in Positive response level I and II was M.M.♩=66-72. However, the tempo of the severely demented group in Positive response level I and II was M.M.♩=63-69.

3. Results

Figure 2 shows the difference in learning process between the severely and non-



severely demented groups of ‘Present My Love’. It took approximately three years for the severely demented clients to reach the Positive responses stage.

FIGURE 3. Learning process of the new song, ‘Present my love’

Severe group' indicates severely demented group and 'non-severe group' indicates non-severely demented group. '♩=' indicates M.M. (Metronome Marking) equals.

4. Discussion

4.1. REGARDING 'SUBJECTIVE TEMPO' IN MUSIC THERAPY PRACTICE

As above-mentioned, from our studies the mean subjective tempo of a familiar working song, 'Saitaro-bushi', was above M.M.♩=80 in non-severe demented group, but in severely demented group, the mean subjective tempo was under M.M.♩=80 (Saji et al. 2003). From Figure 1, however, the mean subjective tempos of familiar children's songs and old Japanese songs in both groups were under M.M.♩=80. Perhaps, because these familiar songs might be in client's childhood memory, and many clients seemed to call them to their mind, while they played together with the song. Therefore it is generally considered that these children's songs and old Japanese songs will become slower and be suitable for the last songs on calming down sessions.

Though the subjective tempo of 'Yuhyake-kotake', 'Kono-michi' was under M.M.♩=60 and suitable for the last closing songs, we considered them not to be suitable for the songs before the last song, 'Present My Love'. Because the tempos under M.M.♩=60 would be in reminiscences for demented groups, in particular severely demented group. Therefore, in order to allow the demented people to learn new songs, we concluded that the song should be played with the subjective tempos of familiar songs within M.M. ♩60-80. Then the clients will join and play the song without strain.

4.2. REGARDING MUSIC THERAPY FOCUSED ON SUBJECTIVE TEMPO

Figure 2 showed that the tempo of non-severely demented group on the each stage was faster than those of severely demented group. When the half of the severely demented group were able to sing, the tempo of 'Present My Love', was M.M. ♩=63 and when the half of the non-severely demented group were able to sing together, the tempo of 'Present My Love', was M.M. ♩=66-69. From this longitudinal research on 'subjective tempo', we found each client had a different subjective

tempo according to his/her condition. The subjective tempo of each individual changes subtly and sensitively from session to session. Therefore from continuous recordings of subjective tempo, we could get hold of the current physical condition of the clients and the progress and the degree of deterioration of their illness.

Also we considered that music therapy focused on subjective tempo led the clients to relax and to take an active part in musical performance, which also allowed them to experience interpersonal communication. Although half of the severely demented group members remained unable to sing or hum the melody of the new song, they did show that they had ability to sense the rhythm of the song, by nodding their heads or tapping their hands with the song. In these ways, some parts of learning ability of every client seemed to have recovered during this research. It was useful to use the subjective tempo of familiar songs in order to introduce and allow clients to learn unfamiliar song. This may indicate that music therapy focusing on subjective tempo do have a great possibility for cerebral revitalization.

TABLE 2. The learning period of each stage

| Response | Negative | Non-negative | Positive I | Positive II | |
|------------------|-----------|--------------|------------|-----------------|-----------------|
| | | | | Half of clients | Most of clients |
| Severe group | 13 months | 11 months | 13 months | 7 months | |
| Non-severe group | 9 months | 4 months | 17 months | 5 months | |

Notes: Participants' responses were classified into three stages of Negative response, Non-negative response, Positive response I and II. In Table 2, severe group indicates severely demented group and non-severe group indicates non-severely demented group. Half or Most of group indicate that the half or most of the group could sing the song. Months show the period spent in each stage.

Table 2 showed there was difference in learning process of 'Present My Love' between the two groups. Non-severely group reached each stage earlier than severely demented group except for Positive responses level I. This research may suggest that the severely demented group is capable of learning a new song, if the song was played to them continuously and in their subjective tempo.

However, we still need more investigations and further researches to confirm the effectiveness of the music therapy approach focused on subjective tempo.

5. Conclusion

The evidences obtained were as followed:

5.1. The Most of non-demented clients have potential to learn a new unfamiliar song, and the half of severely demented clients will be able to sing or listen to it.

5.2. It suggests the approach using subjective tempo is effective to support and maintain learning ability of elderly people with dementia

Acknowledgment

We are grateful to our patients for showing us that they still posses many potentials. We also pay special appreciation to the nursing home for elderly people with dementia in Miyagi, and to Doctor Takashi Ueno, who is a professor of University of Tohoku, for their cooperation. Lastly, I would like to add that this study was supported by the Division for Promotion of Health and Medical Care for the Elderly, Ministry of Health and Welfare, and Miyagi University.

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CHAPTER 49

*Maintaining dialogue - active music
therapy for people living with
Multiple Sclerosis*

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University Witten/Herdecke, Institute
for Music Therapy

Introduction

Dear colleagues, in my talk „Maintaining Dialogue-Active Music Therapy for People living with Multiple Sclerosis“ I will present you some of my practical work from the controlled study „Active Music Therapy for people living with Multiple Sclerosis“, which I did last year in a team consisting of a doctor, a nurse, a statistician and under supervision of David Aldridge.

I start with a video-episode out of this project.

It shows the therapeutic situation as it is representative for my work with patient and therapist improvising music.

In this episode we both play on congas. The patient knows the instrument and he plays it in a characteristic way, without pauses and with many changes in his rhythmic ideas. He seems to be very concentrated on his own playing and the coordination of his hands. In fact he has a medium ataxia in his arms with problems to coordinate them.

I accompany him in different modes: first I try to follow him, then I start to use pauses and play more impulsive rolls on my drum. This attracts his attention to me as a fellow musician and his playing changes.

FIGURE 1. Episode “becoming playful”



As you could hear and see, there were different levels of contact and interaction in this episode.

In my qualitative analysis of all music therapy sessions I identified the individual interaction and contact between patient and therapist as the core-construct for the therapy-course and most important for the changes in therapy.

I will come back later to this idea, and continue now with some informations about MS, as well as the needs of the patients for complementary and alternative therapies.

Then I will present you the findings of my study, showing some quantitative results and the results of my qualitative evaluation, illustrating them with some video-episodes out of the project.

Background

Multiple Sclerosis is the most frequent inflammatory disease of the central nervous system among young adults. There is an estimated number of 2,5 million people with MS worldwide.

A major fact, patients and therapists are confronted with is, that MS is a degenerative disease and there is no cure.

MS causes a variety of symptoms and complex constellations of symptoms, which can affect each area of human life. Main symptoms are fatigue (a special kind of tiredness), sensory, motor and speech problems.

The origins of the disease have been intensively researched in the last decade and it became possible to influence the progress of the disease with medication to some degree.

While medical approaches undoubtedly focus on a functional strategy for treatment, we cannot ignore that diseases like MS have also implications for the performance and appearance of a person in everyday life.

As there are no curative treatments, we are reliant on medical as well as on palliative interventions and rehabilitation.

The frequently life-long process of coping, that begins with the diagnosis of MS, requires continuous efforts to adapt to changing situations and obviously demands a range of therapies which must also consider and encourage a patient's creative abilities.

According to recent publications, MS-patients are expressing increasing interest in alternative and complementary therapies.

One reason for this is that the patients want to play a more active role in coping with the disease. Another reason is the demand for a wider range of therapies to meet social and emotional needs and for mental health in general.

In my research for literature I found five studies about music therapy with MS-patients (Alcock, 2001; Magee, 2002; Rothwell, 1997; Schmidt, 1998; Springer, 2001; Wiens, 1999).

Four with qualitative, one with a quantitative design.

They all have clinical, but different backgrounds and show the benefits of music therapy in giving patients a chance to become active, to become creative, and supporting them in their coping process by singing and composing songs.

Only the quantitative study from Wiens et al. (1999) has a controlled design, showing that a special programme with singing and breathing improves the respiratory muscle strength in patients with advanced multiple sclerosis.

THE STUDY

In my controlled study twenty patients (14 female, 6 male) with MS were involved. Their ages ranged from 29 to 47 years, and with an average disease duration of 11 years.

Ten participants formed the therapy group and ten the control group.

The groups included patients with minimal disability signs as well as patients with disability impairing full daily activities.

The therapy group got three blocks of 8-10 individual sessions of

active music therapy (Nordoff/Robbins approach) over the course of one year.

Exclusion criteria were pregnancy and mental disorders requiring medication.

The protection of data privacy and the ethical aspects were examined and approved by the Ethic Committee of the University of Witten/Herdecke.

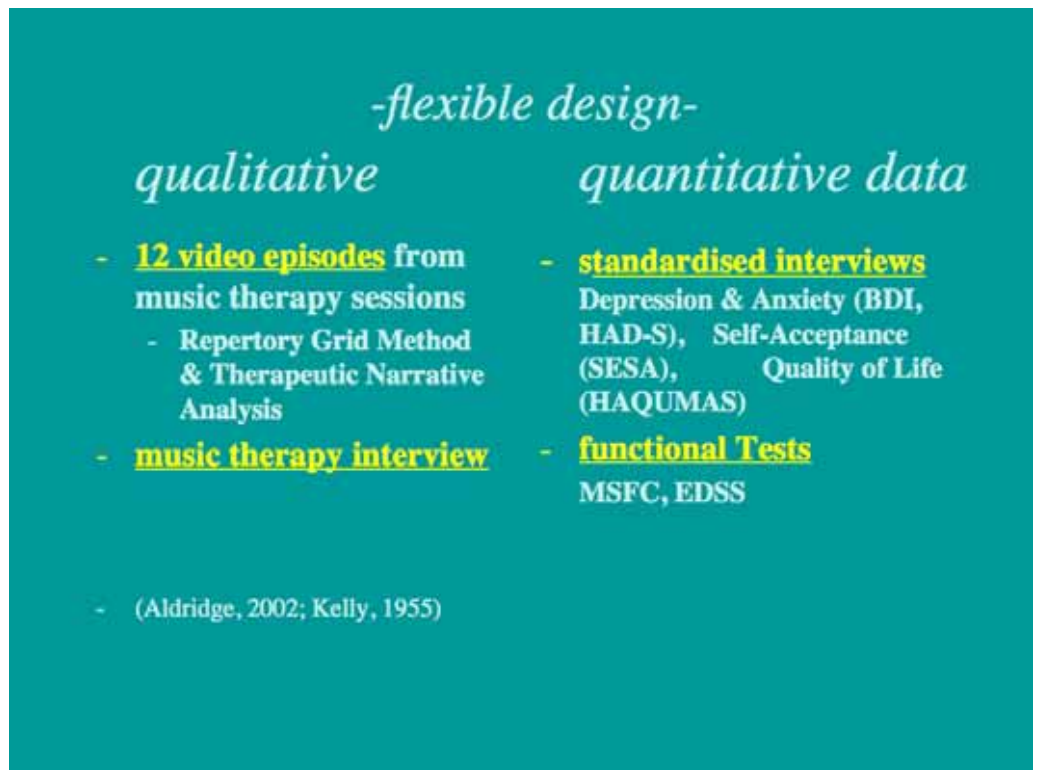
AIMS

The main questions for the study were:

what kind of specific support MS-patients can gain from Active Music Therapy and which changes can be discovered in standardised interviews.

Method

FIGURE 2. Flexible design

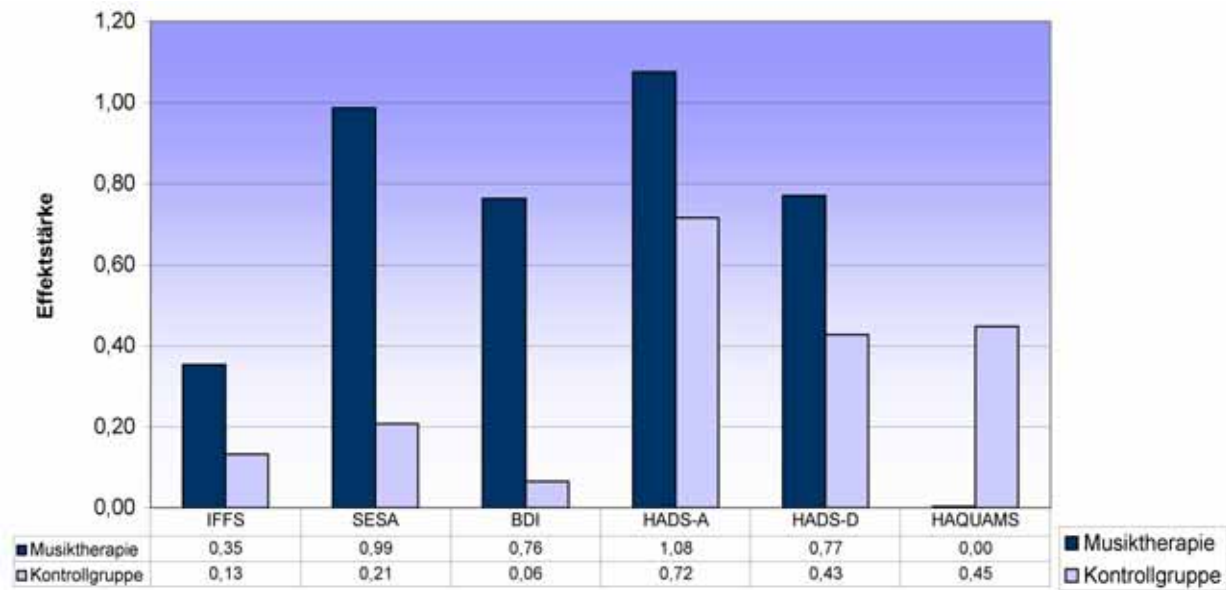


Therefore we implemented a flexible design for the study, collecting qualitative and quantitative data. This data consisted of video episodes from the music therapy sessions. And a music therapy interview, asking participants about their experiences with music therapy.

Both groups were interviewed with a neuropsychological test battery and psychological interviews before therapy began and at three months intervals.

Results

FIGURE 3.



I continue with the quantitative results of the standardised interviews and tests:

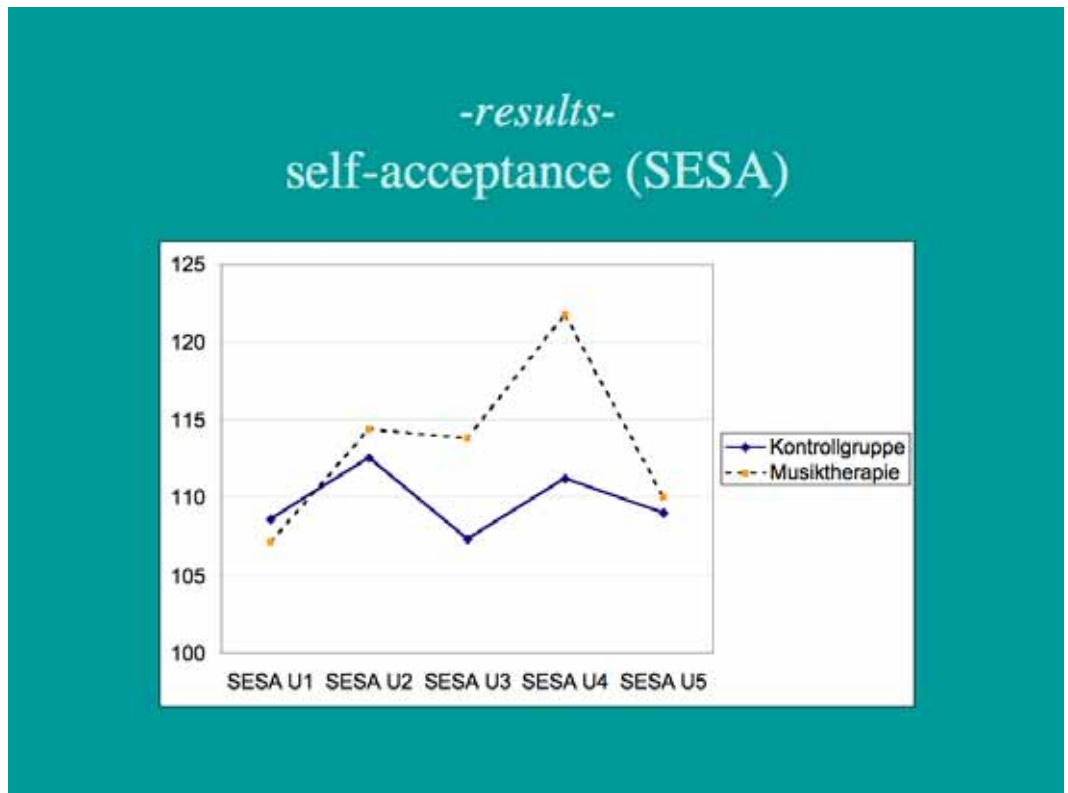
at the start of the study and at the final assessment stage one year later there were no significant differences between the music therapy group and the control group. But improvements were found for the therapy group over time in the scale values of self-acceptance, depression and anxiety. This improvements can be compared as effect sizes (shown here: dark blue: therapy-group; light blue: control-

group). Here we see a considerable effect between the beginning and the end of the therapy on improving self-esteem and relieving depression and anxiety for the people of the music therapy group. Only minimal improvements were found in the subscale „communication“ of the quality of life scale. In both groups there were no recognizable changes in motor and functional abilities.

So we could say, that the form of Creative music therapy used here is valuable for promoting a positive self identity and relieving the emotional burden on a patient. Other music therapy approaches may focus different subjects.

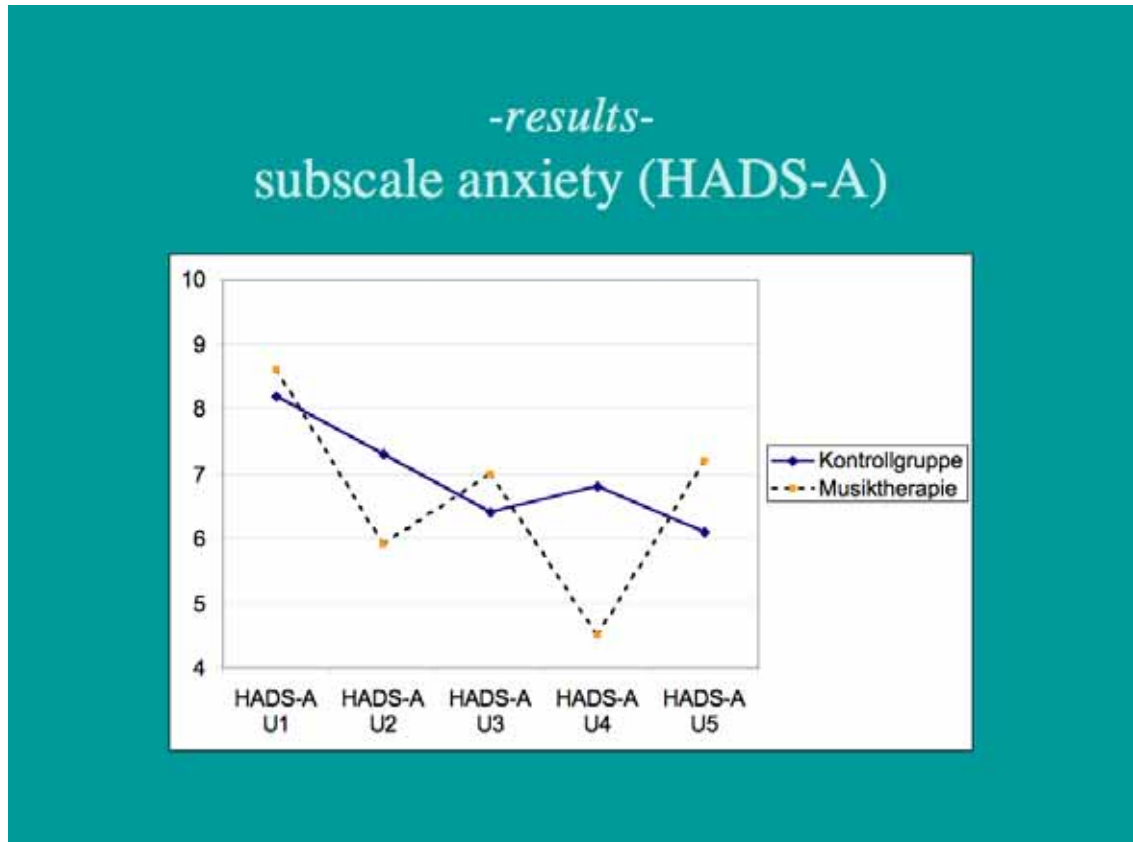
I'd like to show you two results in detail.

FIGURE 4. Self - acceptance (SESA)



The scale of self-acceptance shows a significant effect for the therapy group in self-acceptance, which is comparable to the normal population (the control group is shown in blue, music therapy group is shown in orange).

FIGURE 5. Subscale anxiety (HADS-A)



Significant differences were found for the therapy group and for the control group in the subscale anxiety of the HADS, while the values of the control for depression and self-acceptance did not show any differences over time.

This may be an indication that being recruited for a trial and being regularly assessed is perhaps in itself an important intervention for this group.

I continue with my qualitative evaluation.

I selected 37 video-episodes from the 226 sessions, showing characteristic situations of therapeutic change, which I found in a process of analysing (that means looking at and listening to them) and in discussions with my supervisor David Aldridge. The episodes were evaluated by Kellys Repertory Grid Method and the Therapeutic Narrative Analysis, finding categories for what happens in music therapy.

A main result, the main categorie and core-construct of the qualitative evaluation is the individual contact between MS- patient and therapist in music therapy.

9 PARAMETERS FOR CONTACT IN MUSIC THERAPY

To describe this contact more in detail, I found 9 sub-categories, I call them parameters for contact in music therapy. These parameters are.:

- „attitude of patient and therapist towards therapeutic situation“, that is e.g. do we play or do we exercise and work in music therapy ?
- „the idea for joint music making“, e.g. a melodic motif, a mental image.
- „The question if we improvise or play or sing a composed piece of music
- „the material for music making: e.g the choice of instrument or the voice“
- „the musical roles of patient and therapist“ (this is e.g.the question who leads and who follows?).
- „the ability to structure time“
- „the ability to initiate changes in play“
- For this we have „the dynamic elements of music“

and the ninth parameter

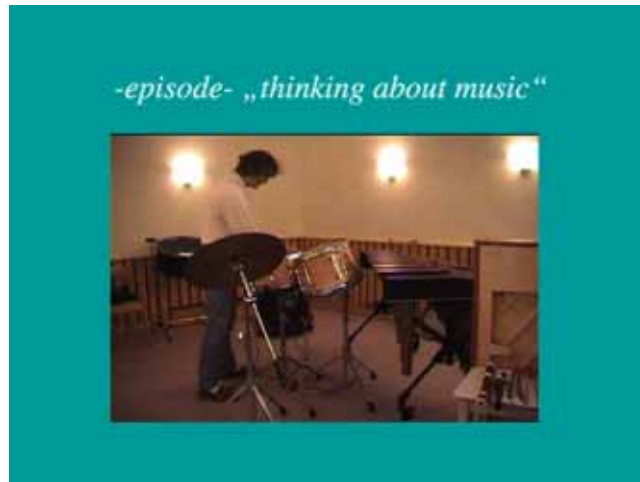
- „movement“ which represents all signs of non-verbal body-language: is there bodily movement or not, is there eye-contact or not.

When I start to describe an episode in terms of this parameters for contact, I see that it is not only one parameter per episode, but two or more parameters that are connected with each other.

In the next episode with he title „thinking about music“ the parameters „attitude towards the situation“, the clearness of the „musical roles“ and the „temporal structure“ are important for the contact, they are connected with each other and can be used to explain the interaction.

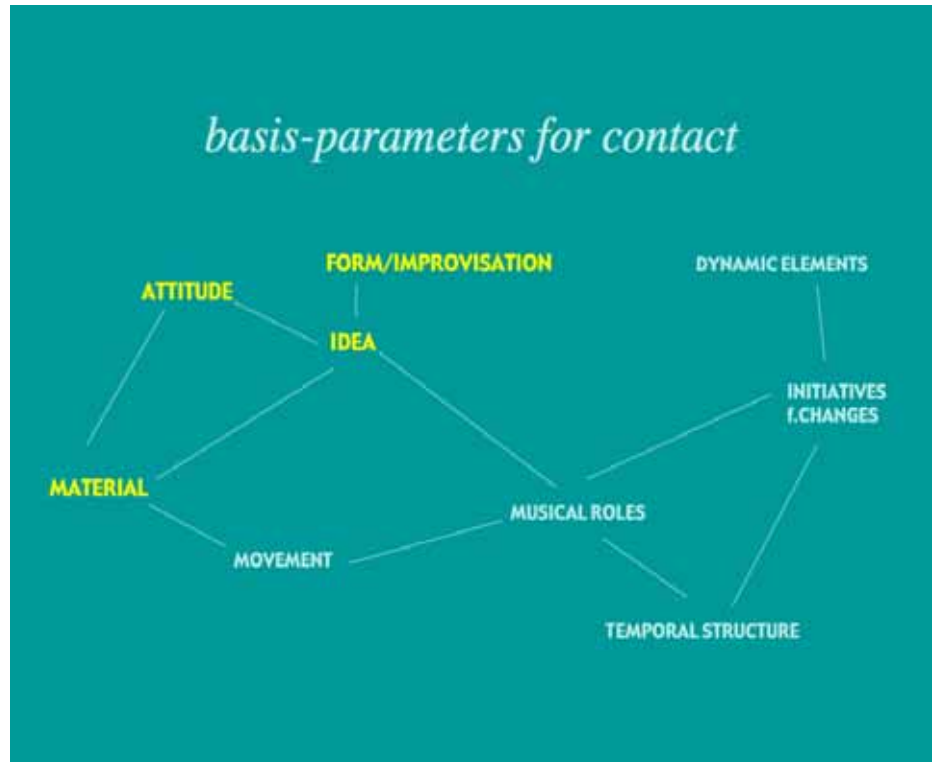
The episode shows the beginning of our playing: the patient has decided to play four drums in the same sequence. You hear what happens, when I try to follow his idea tone for tone, and what happens, when a clear Metrum and Tempo are introduced into the music.

FIGURE 6. Episode “thinking about music”



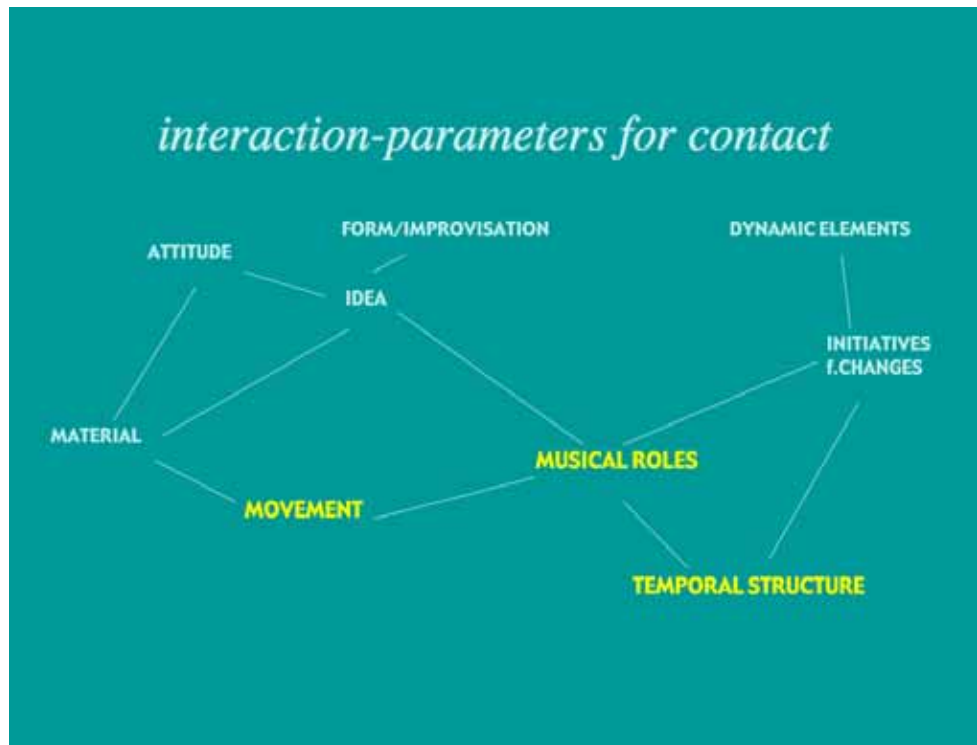
This episode as well as the others show, that parameters for contact are connected with each other and occur together in groups. This groups have dynamic qualities depending on how they are related to each other in various situations. Although I found no hierarchy in the parameter system, I can fix three groups of parameters.

FIGURE 7. Basis parameters for contact - 1



There are the three basis-parameters: „attitude towards therapeutic situation“, the „idea for joint music making“ and the „material“. Basis-parameters stand for conscious or unconscious descisions of patient and therapist for the joint music making. They are a kind of frame for the music therapy sessions. As all parameters their properties can change and lead to another quality of contact.

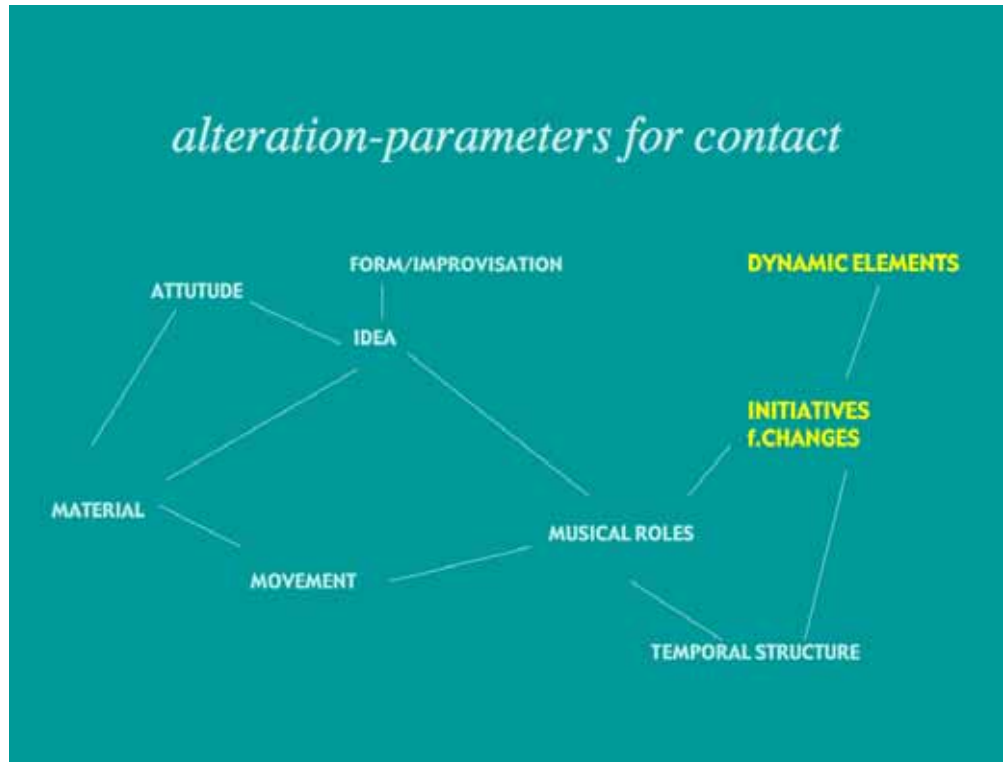
FIGURE 8. Basis parameters for contact - 2



Beside the basis-parameters there are three interaction-parameters.

1. First is „movement“ which stands for all aspects of non-verbal communication like body-movements, gesture or mimic.
2. Second is the „musical roles“: I found that it is very important in music therapy with MS-patients, to help them to find a clear musical role, as we have it in a song for example. : singer and accompanist.
3. The third interaction-parameter is „temporal structure“, which means, that the ability to structure time gives both players or singers a reliable temporal ground for their interaction.

FIGURE 9. Basis parameters for contact - 2



Last but not least there are two alteration-parameters, which stand for changes in music like *ritardando* or *accelerando* but also for changes in style or mood of music.

PHASES OF CONTACT

This three groups of parameters follow each other and can be described as phases for contact in active music therapy with MS-patients.

1. First phase is „exploration“: where patient and therapist become active. Within his activity the patient can orientate himself.
2. The second phase is „interaction“: here a bodily experience comes into music; the patient integrates his body-movements into his musical expression. His body-expressions become part of the encounter.

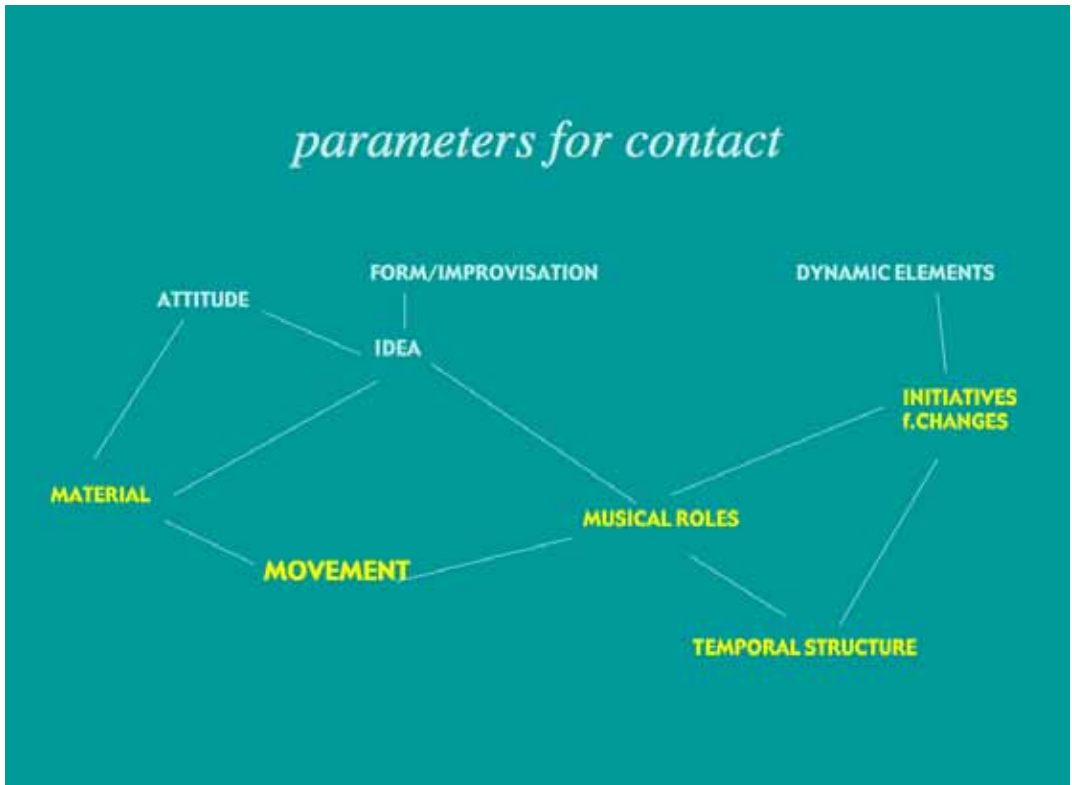
3. The third phase is „development“: in which the expressive repertoire of both, patient and therapist, develops and both find in a new balance.

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3. The third phase is „development“: in which the expressive repertoire of both, patient and therapist, develops and both find in a new balance.

I would like to play some more episodes to you, focussing the second phase of contact „Interaction“ with coordination and bodily experience in music therapy interaction.

I found that active joint music making supports patients bodily experience as well as the expressive repertoire of their bodies.

FIGURE 10.

This happens in many individual ways and is shown in the parameter grafik.

„Movement“ can be supported by

- **MATERIAL:** Instruments which have sounding qualities like gongs, the steel-drum etc. in contrast to rhythmic instruments
- singing songs as well as improvising
- **MUSICAL ROLES** and **TEMPORAL STRUCTURE:** By playing in an alternating, dialogic mode, which challenges both players
- A moving instrument, as it can be seen in the next episode.

In the episode „moving instrument“ the patient is interested in the sound and movements of the ‚ocean drum‘. She says that the instrument makes movements she can-

not do any more. I play with her, but also just listen to her playing. The episode is an example for how a patient needs time to come into contact with her own playing.

FIGURE 11. Episode “moving instrument”.



The episode „singing“ is from the patient you saw before with the conga. He sings freely and brave for his first time in therapy. With his voice as „material“, he is independent from motor functioning and establishes a slow and flexible tempo with rubatos. The music is enlivened by growing tension and relaxation. He seems to enjoy it and there is room for emotional expression and sense of tone in the music.

FIGURE 12. Episode “singing”



For some patients it is not as naturally to sing. One idea was, to combine body movements and singing.

This can be seen in the next episode. The patient was too shy for just singing, so we started to walk through the therapy room, I started to make sounds with my voice in our walking tempo, and the patients was able to join in. You see, how she moves and even starts to dance.

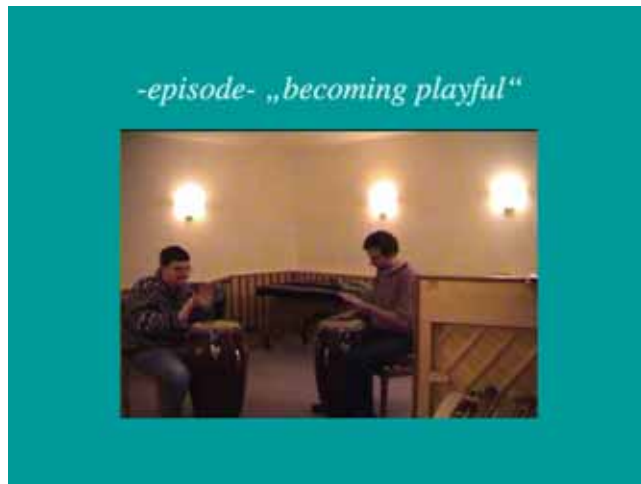
FIGURE 13. Episode “playing and singing”



Bodily experience in active music therapy is also connected with the „musical roles“ and „initiatives for changes“ as you saw it in the first episode.

I'll play it again now. Please notice the sequence after we change our mode from playing simulatenously to an alternating, dialogic one, the patient involves his body more into his playing.

FIGURE 14. Episode “becoming playful”

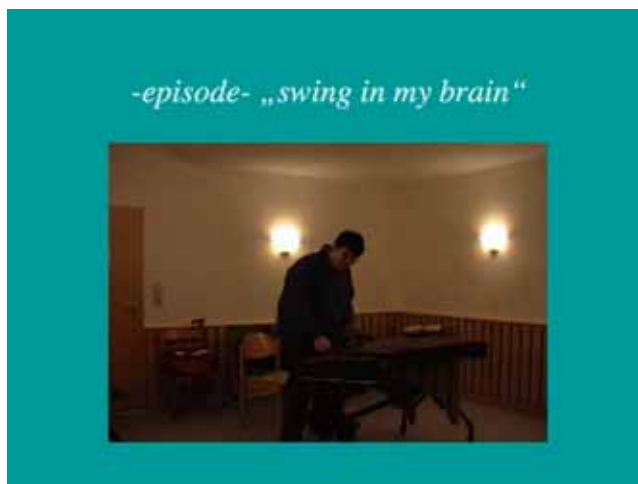


The last episode is from the same patient; it's out of his 10th session and shows, how he transfers his experiences from singing to his playing on a marimbaphone.

His attitude and his idea about playing an instrument changed completely. He communicates with body movements and with an initiative and dynamic playing.

He titled this improvisation: „Swing in my brain“.

FIGURE 15. Episode “Swing in my brain”



Summary

To summarize, I would like to quote from the music therapy interviews, what the patients said about their music therapy experience.

Nine out of ten participants described that it was very important for them to become personally active.

All ten participants reported an immediate improvement in their well-being during the sessions. For eight of them this state continued till the next day and was confirmed by partners or colleagues.

Seven participants described an enhanced perception of themselves with an increasing self-confidence over the course of the therapy. They were increasingly able to let themselves be surprised by their music and by their own previously undiscovered skills.

Music and music therapy are experienced as „something moving“ that reduces negative thoughts about the disease and offers a means of expression for feelings of security, freedom and pleasure.

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CHAPTER 50

*Change - Illustrated by a case in
active music therapy as personal
growth*

Schou, Karin

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Summary

The basis of this thesis is a qualitative retrospective case study in active music therapy as personal growth which is chosen as an illustration of change. The author is both the music therapist and the researcher of the study.

The object is to make research into what change as a phenomenon can be in the specific case, and what the function of the music is in the process of change.

The client is a self referred woman who wants to work with a particular communication problem. The intensity of the music therapy and the unfolding of the change process filled me with awe and made me curious to examine the complexity of this process.

In the first chapter of the thesis central concepts are explained as well as the author's previous knowledge in relation to the object of this research. The basis of the therapeutic approach is Analytical Music Therapy.

The main emphasis is laid on the case, which is introduced and described in chapter two.

The client "Anna" is a normal, intelligent woman in her early thirties who finds herself inhibited in her communication due to her polarized self image, which she wants to change during the music therapy of eight sessions.

During the music therapy the polarization and its components become clear. The theme of control and letting go is expressed in the metaphors the 'judging head' and the 'playful heart'. By allowing herself to become present in the here-and-now, Annas contact with herself is established. This process of change allows Anna to experience feelings that were previously judged by her head as 'wrong'. In free tonal improvisation Anna explores these feelings and the relation between her head and her heart. At the end of the music therapy she has obtained an ability to distinguish what is in her heart and in her head, and she is able to decide which relation between control and letting go is right for her for the time being.

In chapter three the author's therapeutic practice is reflected theoretically. The theories included are selected in accordance with her view on human nature and her therapeutic approach.

The perspectives on change as a phenomenon are reviewed in the theory of analytical psychology and in an existential theory, and specific concepts are explained.

The transformation principle is the basis of change, and self-realization is seen as a basic human

need, which is closely related to creativity and the ability to play. A theory on play and reality is included to contribute to the reflection on play as a parallel to free tonal improvisation as it is employed in active music therapy.

The object of therapy in relation to change is illustrated. How a change process is initiated and which roles responsibility and will play in this is explained. In ending this chapter the contribution of the selected theories as to their reflection of the therapeutic practice are explained.

In chapter four the phenomenological / hermeneutic analysis elaborates on the questions what change can be, and go into details of change in the process, in the relation and in the function of the music. Five improvisations (music examples) are selected and illustrated visually in graphic notations. Two client reports are obtained in the forms of a questionnaire and a semi structured interview. In validating and contributing nuances to the analysis, a phenomenologically inspired research is carried out in structured listener interviews.

Each music example is vertically analysed and the chapter concludes by the horizontal analysis of change in the process in its entirety, and change is explained in the theoretical frame of understanding.

The analyses show how Anna by expressing her sense of powerlessness in music allows for its opposite, omnipotence, to be expressed. In surprising Anna this music awakens her creativity and her ability to play. The music clarifies Anna's polarized self image in a way that connects her with the underlying frustration.

By way of projective identification the function of control is played out by the therapist making room for Anna to let go in the music and to explore what relation between her head and heart are appropriate for her for now.

A progression in the process proves particularly clear in the first three music examples.

The analyses also show changes in the relation during the music therapy as different levels of interacting in the potential space between therapist and client are developed.

In chapter five the findings are discussed in relation to the research questions asked. The discussion therefore falls into two parts: one relating to the object of this thesis and the other relating to the research method.

In selecting the music examples an interim definition of change is hermeneutically transformed into a list of nine criteria that describe a phenomenon, which may be called change. All criteria are met in the change process as a whole in this case. Each change phenomenon can meet some of the criteria.

Triangulation of sources has contributed to the validation of this study. A possible simplification of the procedure of the listener interviews is discussed.

In conclusion, change as a phenomenon in this case shows to be as follows:

- The need for self realization is carried out in the client's need to change her self image
- Creativity awakens as the client surprises her self and is engaged in the here-and-now
- The client sees possibilities in stead of inhibition which exemplifies a creative approach to life
- The relation develops through four levels and the role of the therapist changes as the potential space is established, used and expanded
- Existentially the client finds her personal way of dealing with the challenges of life by deciding which relation between control and letting go is right for her
- In an analytical psychological perspective the psychic structure of the client becomes more flexible
- The process in parts and as a whole consist of four levels of relating to the process
- Change is realized in four existential dimensions
- Responsibility and will show in the client's ability and will to be present in the here-and-now at times of emotional challenge

The music has the following functions in the change process:

- Music as a field of play allows the client to explore former unconscious feelings and support her being present in the process here-and-now
- Music helps the client to let go
- Music allows for the client's exploration of her omnipotence
- Music reflects the polarized self image of the client and connects her to its frustration
- Music creates the potential for a dialogue between opposite poles
- Music makes room for the client to express and embody a new psychic structure
- Music reflects the relation and its levels of interaction throughout the change process

The theory of gestalt therapy and levels of contact could contribute with different perspectives on change processes, as could Stern with his minute research into the interactions of infants and their primary care taker.

Summary

This case is one illustration of change processes, which cannot be generalized. May others be inspired to further elaboration into this basic condition of life.

CHAPTER 51

*Music therapy in psycho-oncology –
A gender comparison*

A research project of the Master's
Degree programme in Music Therapy,
University of Applied Sciences
Frankfurt/Main, Germany

Seidel, Almut

Abstract

This article documents a music-therapy research project in the psycho-oncological care of both, male and female cancer patients at the transition point between curative and palliative care in their illness. This article discusses the far-reaching implications at the institutional, conceptual, methodological and personal levels. In addition to the detailed description of this field of work, there is a focus on two particular aspects of the research results: first, gender-specific reception to the opportunity of having music-therapy and second, the relationship between the spoken word and making music in the therapy sessions, with the potential of each as an integrating or polarising healing factor.

Introduction

The gender study that I will report in this talk is based on the following data:

- work with cancer patients
- with different types of cancer
- in 3 hospitals
- patients of all ages, with a concentration between 21 – 68 years
- stadium of the illness is the transition point from curative to palliative treatment*
- exactly the same numbers of male and female patients
- working with male and female therapists
- emphasis on individual active music therapy with exclusion of vocal work
- research attention paid to the musical as well as verbal interaction
- combination of qualitative and quantitative research approaches

*In fact, we now know that six months after completion of the data collection phase of the project more than 50% of the patients had died.

Aims

The intention of the study is to find out what music, working with music and the therapeutic setting means in working with cancer patients and how patients of both sexes receive it. Our initial hypothesis was:

We suspect that there must be differences in the way that cancer patients make use of the possibility of music therapy due to the following factors:

- the seriousness and finality of a diagnosis with cancer on the one hand,
- and, on the other, the nature of music and music therapy:
that is, that music as a therapeutic agent appeals to the emotionality, expressiveness and ability of the patient to be in dialogue,
and that music therapy encourages active and creative coping strategies.

The degree to which this response is gender specific, or the degree to which there is a gender-specific approach to coping with the illness seems to be an important question (Brähler & Felder 1999; Meadows 2002).

We began work on this project in the spring of 2002 and will complete it by publishing our results in book form (Seidel 2005).

I will now like to describe our research design which is shown in the following table.

TABLE 1. Research design

| | Local Practitioners | External Describ |
|-----------------------|--|---|
| Personal level | • Hospital 1 Music therapist 1 f-> 6 Patients f -> 6 Patients m | • Describer 1 • Describer 2 • Describer 3 |
| | • Hospital 2 Music therapist 2 f -> 6 Patients f -> 6 Patients m | • Describer 4 • Coordinator |
| | • Hospital 3 Music therapist 3 m-> 6 Patients f -> 6 Patients m | |
| | | |

TABLE 1. Research design

| | | |
|--|--|--|
| Data / Material Level | <ul style="list-style-type: none">• Patient statistics (230 Patients)• Patient data (36 Patients)• Short description of the course of therapy (36 Patients)• Audio recording of one selected session per patient• Music descriptions by patient and therapist of improvisation from selected session• Quantitative Pre- and Post-Test | <ul style="list-style-type: none">• Music descriptions from 18 selected patients using morphological method |
| Evalu-ation / Interpretatio n Level | <ul style="list-style-type: none">• External situation:• Internal situation:• Relationship between verbal and musical interaction• Pre- and Post-Test• Gender comparison | <ul style="list-style-type: none">• Setting variables and conditions• emotional coping strategies, assumed effect |

Methods

SUBJECTS AND INTERVENTION

We have three groups of persons who have taken part in the project:

1. the music therapists or practitioners on site
2. the external music therapists who have studied the music of the patients
3. the research team

You will see that we have attempted to have balanced representation of men and women in each group (Behnke & Meuser 1999; Strauss 1991).

The local practitioners were charged with giving us a bundle of material; you can see this in Table 1 on page 1460 on level 2, the data and materials level. We received statistics, that is, an overview of patients treated, from a year's work from each therapist. This included data concerning sex, age of the patients, and the number and length of sessions as well as the method of work in the sessions. At this level we divided the methods used into three general categories:

- active music therapy
- receptive music therapy
- talking without music

DATA COLLECTION

Then a selection of 12 patients per therapist, 6 male and 6 female, was made based on the work of the practitioners from approximately the previous 18 months. The selection of patients was made by the therapists themselves after we had determined the total number of patients we wished to have. We received personal data for each patient including a short medical history and a summary of the treatment given in hospital. Therapists documented the course of the therapy by making notes after each session. Here we asked for detailed information about the methodological approach including making music, listening to music, playing for the patient, body work, etc.

Out of the total course of therapy with each patient, the practitioner selected one session that he or she subjectively felt was significant in illustrating the therapy process or the situation of the patient. We received an audio recording of this session. One of the music improvisations in the session was described by the patient – as much as was possible for him or her. This was important for the research design and so the therapists gave the patients enough time and space to describe their experiences of making music. Afterwards the therapists also wrote a description of the music from their perspective.

QUESTIONNAIRES

In addition, patients were asked to fill out a questionnaire before and after each session documenting the way they felt. The instrument used was the “Basler Befindlichkeitsskala” (BBS). The questionnaire (Hobi 1985) comprises 16 items such as

- calm and nervous
- withdrawn and open
- attentive and distracted

that are grouped into 4 main categories (see Basler Scale: four sub-groups). The sum of the values for all four give an overall value for the condition of the person.

FIGURE 1. Basler Scale: four sub-groups

- intra-emotional state of balance
- vitality
- alertness
- social extroversion

BLINDFOLD MORPHOLOGICAL DESCRIPTION

For the evaluation of the improvised music we chose the Salber's method of morphological description through which one can describe the experience of emotional or psychological events (Salber 1980). Only the unbiased emotional response of the listener to the emotional state being expressed by the other person gives access to the fundamental inner state of the other. On a comparable level, the expert's listening to the improvised music is the morphological descriptive work. Without any further information about the case, the expert listens to the music and then writes down impressions, images, associations, stories, memories and reactions elicited by the music heard.

We modified the morphological approach in the following ways in order to achieve our goals: we asked 4 music therapists to undertake this descriptive work independent of each other and without any knowledge of the source of the music they were hearing, in a blindfold experiment. This means that they received no information about where session had taken place, nor the identities of therapist and patient, about the illness and the clinical background nor the question our research was attempting to answer. In this context, you can see why we excluded vocal elements (Tischer 1993) in the sessions selected for analysis.

The describers were asked to listen to and describe the music on 5 consecutive days. We wanted to see if the experience of the music changed or solidified when listened to in such an intensive way. Of course, we also wanted to make use of 4

different ways of hearing and experiencing the music. And so, we speak of an internal and external comparison.

The selection of patients whose music was sent to the describers was made from those for whom a full set of data was available; the selected improvisations also typified the responses of patients and therapists in the music therapy session – these characteristics had become increasingly clear through our memos.

TRIANGULATION

All methodological steps were decided in the core team in which three subjective perceptions confronted each other (Hurrelmann & Laaser 1998; Soeffner 1979). So, in the total evaluation of the data, we are dealing with three viewpoints, that of the local practitioner, the external describer and the core team: we hope that this approach assures controlled subjectivity.

FIGURE 2. Triangular dynamic

- music therapists as local practitioners
- external describers in blindfold experiment
- core team of experts

In order to explore the connection between the verbal and musical interaction of a session, we transcribed 13 of the 18 sessions that we had as audio recordings. The selection was made in order to have a balance of male and female patients as well as to cover the work of all the therapists in local practice. We decided not to transcribe all 18 sessions because at a certain point the research material was saturated.

Inclusion of this material was not planned from the beginning; we made this decision in response to the tension which became apparent between the external describers' perception of the music and the rest of the data on hand.

The purpose of this comprehensive and carefully documented collection of data can be seen in table 1 on the 3rd level – the evaluation and interpretation level. We considered the so-called external circumstances – the questions of time and place, the instruments selected, the presence of other people and so on – in order to deduct a pattern under which the therapy was conducted. We wanted to discover this pattern in order to make a contribution to the discussion on concepts of music-therapy in

the clinical context. Results can be found in the book published in 2005 (Seidel 2005)

Then the question arose of how patients deal with the music therapy through their experience and behavior, and how to assess the effect of music therapy work. It was necessary at this point to reduce the data and focus it in order to elicit themes from it. We used two theoretical models as screens through which to look at all the data we had on each patient with specific attention to themes which were significant with regard to coping with the disease.

1.) FIVE LEVELS OF AWARENESS

The first model emerged from the data itself: we identified 5 levels of awareness that are particularly important for patients with cancer. These core categories are:

- physical or body awareness
- emotions
- imagination
- ideas or thoughts/understanding
- interaction with others

Table 2 shows the evaluation sheet we developed and used to work with the data we had.

TABLE 2. Evaluation sheet

| | | | | |
|-------------------------------|----------|--------------------|-------------|---------------|
| Client: | Session: | Instrument client: | Instrument: | |
| Awareness level | physical | emotional | imagination | understanding |
| before the session | | | | |
| until music production begins | | | | |

TABLE 2. Evaluation sheet

| | | | | |
|--|--|--|--|--|
| External describer's experience of the music | | | | |
| Music therapist's experience of the music | | | | |
| Patient's experience of the music | | | | |
| after the music production phase | | | | |

You can see in table 2 that we divided the information into an objective section based on the notes of the session, and a subjective one based on the descriptive level. Both levels were then compared and an interpretation was derived.

The process of working with this comprehensive amount of data was as follows: each of the three experts on the research team reviewed the data independently and began to reduce it to a more compressed form. Then working together, all emphases that were commonly agreed upon were entered into the tables and used for interpretation.

2.) MULTI COMPONENT MODEL OF EMOTION

Now to the second model:

In order to make a gender comparison and to make the qualitative data quantifiable (Behnke & Meuser 1999), as well as to generate a theoretical model, we used a model which stems from the psychology of emotions. This multi-component model includes:

FIGURE 3. Emotion model (Bernd Tischer 1993) version I

- subjective experience (emotion)

- cognitive (and imaginative) experience
- physiological process (body experience)
- interaction behaviour
- situational aspects

The model emphasizes the process character of emotionality and examines the function of emotional development in interaction; these are put into a valencing scheme and allow a method of measurement that results in identifying so-called emotion types. In this way a quantifiable instrument is introduced that allows us to develop our results within a broader theoretical model and thereby in an established theory, thus making a bridge to the scientific community. The inter-connection between our data categories and the emotion concept are shown in the next table 3.

TABLE 3. Quadrantenmodell

| | |
|---|--|
| <p>1</p> <p>Away from oneself - Patient controls the surroundings</p> <p><i>Physical level:</i> Patient is very tense</p> <p><i>Emotional level:</i> Pt. is angry, rejecting, under pressure</p> <p><i>Imagination:</i> Images of (struggle for) survival</p> <p><i>Understanding:</i> Patient feels autonomous</p> <p><i>Interaction level:</i> Patient controls every contact</p> <p>Tendency to act:</p> <p>Patient feels under attack and resists with intensity</p> | <p>2</p> <p><i>Toward oneself</i> – Patient controls the surroundings</p> <p><i>Physical level:</i> Patient is energized</p> <p><i>Emotional level:</i> Patient is able to feel</p> <p><i>Imagination:</i> rich imaginative abilities</p> <p><i>Understanding:</i> Pt. actively seeks w</p> <p><i>Interaction level:</i> Patient is in dialo</p> <p>Tendency to act:</p> <p>Patient signals what he/she wants an</p> |
| <p>3</p> <p>Away from other(s) – Surroundings control the patient</p> <p><i>Physical level:</i> Patient is in pain, strength for living is waning</p> <p><i>Emotional level:</i> Patient feels afraid, sad, depressive</p> <p><i>Imagination:</i> Images of helplessness</p> <p><i>Understanding:</i> Patient feels dependent on others, not in control</p> <p><i>Interaction level:</i> Patient is withdrawn, not in contact</p> <p>Tendency to act:</p> <p>Patient closes down and retreats from living</p> | <p>4</p> <p>Toward other(s) – Surroundings control the patient</p> <p><i>Physical level:</i> Patient is cut off from</p> <p><i>Emotion:</i> Patient longs for deliveran</p> <p><i>Imaginations:</i> Images of dissolution</p> <p><i>Understanding:</i> Patient lets everyth</p> <p><i>Interaction level:</i> Patient desires fee</p> <p>Tendency to act:</p> <p>Patient gives in and gives up</p> |

SEQUENTIAL TEXT ANALYSIS

In order to explore the relationship between the verbal and musical interaction, we used the method of sequential text analysis of the transcriptions of the audio recordings. This method involves four steps (see Oevermann 1979):

1. Transcription of the verbal material in the session with medium exactness
2. Documentation of the obvious structure of the text by sequential paraphrasing of the sections of the transcript
3. Extensive interpretation of the latent meaning structure using Oevermann's objective hermeneutic method
4. Comparison of the descriptions of the verbal text and the descriptions of the music

The last step in the analysis of the material was the statistical analysis of the pre- and post-test. I will talk about some of the results later.

GENDER COMPARISON

Finally, the gender comparison was an aspect of the concluding assessment and interpretation of the research results.

Interpretation and critical appraisal of the research results

In our analysis we dealt with three issues:

1. The question of method: active and/or receptive music therapy, talking
2. The institutional dilemma: resistance / music therapy as intermediate space
3. Gender mainstreaming – also in music therapy?

1. THE QUESTION OF METHOD: ACTIVE AND/OR RECEPTIVE MUSIC THERAPY, TALKING

We have overwhelming evidence in our research that music therapy in oncology is in most cases receptive, that is sound meditation on the monochord within a guided relaxation in which music takes over a background function (Verres & Rittner

1997). This form of music production is not musically or therapeutically very demanding and can easily distort the image of music therapy as a profession.

Rarely, there is also a special form of receptive music therapy which is called “Für-Spielen” in Germany, which means that the therapist plays simple instrumental music for the patient.

The therapists gave us the following reasons for this: The patients are physically too weak. They are completely exhausted, their pain is overwhelming and they are challenged enough in other areas. Usually they are not able to walk or must stay in bed to receive infusions. These are plausible reasons, which cannot be dismissed.

Consequently our research design proved to be misconceived since active music therapy appeared as an artefact. A certain pressure existed to acquire the patients for the research. In order to fulfill the research design, the therapists made an effort to change their strategy and to do more active music therapy – whether at the bedside, in the patient’s room or in the music therapy room.

Then came the first insights: it does work to do active music therapy! It brings results, perhaps even more than receptive music therapy. What is this “more”?

Receptive music therapy fits in with the courses of medical treatment: a specific therapy is administered (medication, radiation, operation) and then one waits for the effect. Apart from bearing and suffering through all the side-effects, this waiting is the only active step in the healing cycle (Verres & Klusmann 1997; Gruhlke, Bailer & Kächele 1999; Kappauf & Gallmeier 1995).

Receptive music therapy is the same procedure: in this case a sound induction is „administered“ and one hopes for the relaxation and wellness effect. When this offer is matched with a significant amount of suggestion with regard to the positive effect of the treatment, a degree of autosuggestion cannot be excluded. This carries on through the post-test. It is simply assumed that the expected positive effect has been achieved, or is confirmed by the largely positive comments of the patients, to the degree that they express themselves at all.

Active music therapy, on the other hand, is a challenge to patients to give up this stance of being a receiver and to take the instrument of healing literally into their own hands. In that the patients take the initiative they can overcome some of the regressive tendencies that the illness brings with it. This encourages them to produce their autosuggestion in another direction, namely “I can still do it, that has nothing to do with my illness and the physical and emotional restrictions, that is a

field with no land mines, that is harmless.” They experience music making as a small step in the direction of reclaiming their autonomy which they have largely relinquished in hospital; they can “forget” themselves a little – that is, they can forget the “sick” self for a time (Weber 1999).

It becomes clear to the patient, either explicitly or implicitly, that music therapy can achieve something that lies between, between relaxation and self-healing (Decker-Voigt & Escher 1994). Actively produced music can make tensions audible and ideally can regulate tension. It can make audible what patient is not able to express in words: his restlessness and inner conflict, his anger, resignation, physical and emotional numbness and feeling forlorn (Aldridge 1999). The patient can also feel his deep desire to full life strength and his passionate yes to living even if this is an illusory dream and a sad longing for unattainable harmony. Active music therapy is appropriate for persons who are not able to speak about their condition but are willing to listen attentively to their own being. This is, however, far removed from relaxing, distraction and relief or from simple “balsam” for the soul, as one patient said (Verres & Klusmann 1997).

2. THE INSTITUTIONAL DILEMMA: RESISTANCE/ MUSIC THERAPY AS AN INTERMEDIATE SPACE

We asked ourselves what makes it so difficult to do active music therapy? Why hasn’t active music therapy become the method of choice, why is it, in fact, occasionally avoided?

We became aware of another contradiction:

In the analysis of the verbal interaction we realised that therapists take pains to describe what the positive effects of music therapy can be; this often takes the form of extensive instructions. It also became clear that patients speak very little about their emotional experience after they have made music. Often, if they talk at all, they focus on external aspects such as how to handle the instrument or how it was constructed or they talk about their previous experiences with music. If there is talk about the music just produced, therapists tend to make positive value judgements and toward euphemisms. It seems that something is contained in the music which is excluded from conscious examination.

On the whole the patients experience the contact as positive and they are interested in this form of therapy. This is shown in the few statistically significant results of the pre- and post-tests: the analysis showed that there was a significant increase in

figures for all four factors as well as for the sum of the four, clearly documenting that patients experienced positive benefits from music therapy.

A different picture is revealed in the description of the music:

- There is no real understanding of the suffering of the patient, neither by the patient nor the therapist.
- Other feelings appear, such as feeling forlorn, loneliness, not being noticed, losing oneself or falling apart. Feeling of numbness and being at the mercy of external influences.
- In being with someone, which is so much desired, something always drifts apart and destroys the hint of commonality.
- The loneliness cannot be abolished.
- There seems to be a compulsion to believe that all will be well, that all is possible and convincing. However: true conviction is missing.
- Not-understanding actually cloaks rejection.
- The patient has to go through “hell” alone (the certainty of disease, the suffering, death); one can accompany the patient, but can offer him or her no real help.

These findings are confirmed and quantified through the typology of the emotions model; the type of patient that can most often be identified with equal representation of men and women is Type 3. I will show you this segment of the quadrant model (Table 3 on page 1468) again.

FIGURE 4. Type 3

Away from other(s) – Surroundings control the patient

- *Physical level:* Patient is in pain, strength for living is waning
- *Emotional level:* Patient feels afraid, sad, depressive
- *Imagination:* Images of helplessness
- *Understanding:* Patient feels dependent on others, not in control
- *Interaction level:* Patient is withdrawn, not in contact

Tendency to act:

Patient closes down and retreats from living

There seems to be method in the contradiction in the findings. One could describe it as repression of the oppressive reality and as resistance.

How can this be explained?

The music therapy work in our research project dealt with 6 conflict fields that produce the reaction of resistance.

1. general image of music in our society
2. hospital's instructions on purpose of music therapy
3. music therapist's professional understanding
4. research design – focus on active music therapy
5. resistance of the patient
6. tension between curative and palliative care

First of all, there is the **general image of music that prevails in our society**. Music seems to be something very nice and always makes you feel good. Music relaxes and regulates feelings; music lifts our spirits and makes us happy. And if it doesn't do that, we turn it off – literally, also in the sense of not dealing with it.

Secondly, the **hospital expressly instructs the music therapist to make a contribution to securing the compliance of the patient**. The patient is to feel as well as possible under the circumstances.

Thirdly, there is the **professional understanding of music therapy**, which means using music and the music therapy setting to cope with the illness. Ideally, this means depiction of the conflict and resolution. In this regard, there are principally no limitations to using all methods that are recognized as music therapy. But it is also clear that music therapists have a very sophisticated understanding of the effect of music. And therefore, they cannot exclude the possibility that music will produce other responses than calmness, relaxation, and relief.

Fourthly, **the research design called for the investigation of active music therapy**. However, it was soon apparent that this was and is not the rule in practice of music therapy in psycho-oncology.

Fifthly, we are dealing with the **resistance of the patient which we could describe as protective resistance**. This is understandable in the light of the desolate physical condition of the patients and in the light of the demands that the other treatments make on them. Furthermore, active production of music provides a wealth of new

and unusual experiences so that the patient undoubtedly experiences it as quite demanding.

And finally, the sixth conflict field is **the tension between curative and palliative care**. As long as medical treatment is based on the hope that life can be prolonged for the patient, the music therapist must fit in so that he or she does not undermine these efforts. And therapists certainly do not want to lose their jobs. So their orientation remains diffuse and becomes an individual problem to solve. It would be much easier to conceive of and carry out music therapy as pure palliation.

Thus, music therapy is pulled in many directions.

But something does take place in the course of active music therapy, possibly in receptive music therapy as well – that is documented by the external expert's assessment. This can, perhaps, be explained as follows:

Hospitalization means that, although all are fully aware of the potentially lethal outcome of the illness, everything possible is being done to save life (LeShan 1999). This is the ethical principle, and so hope must be the dominant attitude (Aldridge 1999). This is the internal stance of the medical staff, otherwise a professional identity would be unimaginable.

This principle can be maintained everywhere else – but not in music. Since music affects the unconscious of an individual, the patient cannot control the elements that begin to surface. What is working in the unconscious of the patient finds an outlet.

In this context, Winnicott's model of „intermediate space“ was helpful for us. It serves as a bridge between inner and outer realities. The inner realm is the individual and her experiences. The outer realm is the surrounding reality, in this case, the illness, treatment objectives and methods.

The music generated by patient and therapist functions as intermediate space as

- the inner reality does not remain hidden but is brought into the open
- what is brought into the open does not need to be put into words, in that it has already found a form of expression
- having expressed the inner reality, it is „enough,“ that is, the „thing“ has been given a name – the monster of death, illness, destruction, hopelessness has been given a face, or a sound.

Therefore, music therapy should be understood as

- the space into which this experience from the borderlands can flow without having to be put into words or grasped mentally.
- a place where these truths can exist and must not be banned as they are in the clinical and private daily reality.
- an opportunity for that which is incomprehensible, nonetheless, to be grasped emotionally. The music shows that although the patient is not yet able to understand the illness, the threat and the knowledge of his own fleeting life, the music produced shows that the spirit of the person has already apprehended this reality.

3. GENDER MAIN STREAMING – IS IT RELEVANT FOR MUSIC THERAPY?

In our research a common observation was confirmed:

As long as there is no conceptional obligation, thereby no institutional monitoring, men are excluded from psycho-oncological music therapy.

- N=148 Patients in 3 clinics
- Women 104 = 72%
- Men 42 = 28%

If they end up in music therapy, either through their own initiative or by chance, through something like gender-focused research (Brähler & Felder 1999; Behnke & Meuser 1999), then they are more likely to experience receptive music therapy if there is music at all (Krantz 1999).

TABLE 4. Methods used

| | Active MT | Receptive MT | Talking |
|-------|-----------|--------------|---------|
| Women | 26% | 50% | 24% |
| Men | 19% | 33% | 48% |

This confirms a common cliché – that men enjoy being waited on by women, they take what supposedly belongs to them without making any efforts of their own,

they avoid emotional conflict (Brandes 1992; Hollstein 1999). But they remain alone in their suffering (Neumann & Sufke 2004). A two-class society is created.

„There is no gender-neutral reality”, is one of the basic tenets of the gender-mainstreaming movement (Kolip 2000; Meadows 2002). The assumption is that all societal enterprises, also music therapy, wherever they are found, should take into account the life situation and interests of both men and women from the beginning and throughout the further development of the initiative. The goal is the equality of both sexes.

At no time or place anywhere in the world has there been any indication that men have a less intensive, less motivated, less elementary or emotional approach to music (Sieg 1995). Men may demonstrate a different affinity for music than women, or may conceptualize it differently, but they need music just as urgently as a life-giving, and life-preserving element in their lives as women (Krantz 1999). That is even more true in such extreme situations as life-threatening illness (Aldridge 1999; Renz 2000).

We did not document any differences in behaviour, in approach to music therapy, or in results of the therapy between the 18 male patients and the 18 female patients in the study. This applies to all parameters that we studied – from the choice of music instrument and its use, to the transition from talking to making music and vice-versa and to the statistics of the pre- and posttest.

We have attempted to show that the clinical reality – when not influenced – makes differences and that the practice of music therapy is far removed from the ideas of gender-mainstreaming. Carrying these ideas into the professional field of music therapy and in the training programmes was and is one of the intentions of this study. In our eyes, psycho-oncological music therapy is a particularly vivid and impressive example of the quality of perception and feeling, the ability to listen to the interior realities and to put them into external expression as a way of coping with illness and life that men as well as women need (Maschewsky-Schneider 1997). Men need it no less, no less naturally, or unquestionably than women. In my eyes, professional quality and responsibility begins at this point.

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CHAPTER 52

*Phenomena of health and pathology
in music therapy*

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Abstract

In the following presentation, I will describe and analyze specific recurrent phenomena that emerge during the process of music therapy and represent or symbolize real-life issues. These include phenomena of health as well as of pathology, which enable us to diagnose and make therapeutic considerations. From positive musical aggression, constructive ventilation and lamentation to the phenomenon of repetitive monotonic drumming (devoid of changes in rhythm and dynamics) characteristic of cases involving pathological mourning; difficulties in beginning instrumental playing, typical in cases of expressive aphasia; musical components of passive-aggressiveness; musical expression of defense mechanisms; musical components of compulsive-obsessive behavior; cutting the end of sentences in songs, typical of certain psychiatric disorders; splitting and more. The presentation will combine theory and practice, followed by recorded and video-filmed examples.

Introduction

We accept the musical expression in music therapy as meaningful, even when it sounds very simple, or “not musical”, or primitive. The artistic meaning is not the issue but rather the psychic content that emerges in between and behind the lines.

This content might use music as a symbol, representation, direct expression of emotion, etc. Most often, the patient expresses a feeling in his/her musical action long before he/she is able to do it verbally and typically without being aware of the expressive content. In active music therapy, in which improvisation is one of the main techniques and approaches, the musical chains act as free associations in verbal analytical therapy. Most of the activity begins at the subconscious level, but gradually this process might help patients become better connected with their authentic experiences. In free association, key words can facilitate understanding of inner content. So do key musical events, motives or repetitive elements in clinical improvisation. Indeed, a music therapist must listen carefully to the double meaning of the patient’s musical manifestation and analyze the pure musical content as well as the extra-musical analogies.

A. Splitting

Danny¹ was eight years old when he was first referred to music therapy. Born after a full-term pregnancy, at the age of few months he began to show signs of uncontrolled rage and temper-tantrum. His parents, both in medical professions, firmly rejected intervention and tended to blame the nursery system. As a result, the child was moved from one nursery school to another, unable to develop any ongoing bonds. In elementary school, he failed to cope with academic requirements and social demands: his aggressiveness endangered children and staff, he regularly threw stones and other objects at people, stabbed peers with knives stolen from the kitchen, could not concentrate on his studies, and despite his normal intelligence and learning abilities, at the age of eight he still could not read, write or calculate. Danny was soon named The Devil by his class mates, and found himself socially isolated. Subsequently, his parents were compelled by school authorities to search out the psychiatric intervention, and Danny was diagnosed as suffering from an *Organically-based Developmental Disorder*. During four months of psychiatric

1. All names are fictitious in order to keep the professional ethics.

treatment, Danny did not cooperate and the psychiatrist recommended music therapy, stating the following reasons:

the child has natural tendencies toward music, his parents felt less threatened by modality and because of the ability of music to circumvent words and create an alternative mode of communication.

The intake process in Developmental-Integrative Music Therapy (Sekeles, 1996) mainly entails spontaneous and/or planned observation of musical activity according to certain scales of development. In Danny's intake, he initiated a war between a big drum and a cymbal, just a few minutes after he entered the clinic (1st recorded example: War between the drum & the cymbal). At the end of his percussive experience, he commented: "The good cymbal defeated the bad drum, but they won't be friends, neither will they play together". This was the first meeting, and the first time Danny expressed splitting by using two musical instruments in a symbolic way, and portrayed an emotional condition through music. Over the 3 years of therapy that ensued, we worked through this issue which had clearly divided his entire world into black and white. Working through involved music as well as speech. Improvisations, as well as "Clarification, verbalization and interpretation, used consistently, reduce anxieties as they arise, dissolve crippling defenses before they become pathogenic, and open up, or keep open, outlets for drive activity which bring relief" (Anna Freud, 1965: 218).

Splitting, as analyzed by Melanie Klein (1986), can involve both the object and the ego. The earliest splitting between the good and the bad self, and between the good and the bad object, serves as a primitive ego mechanism and defense against anxiety. In cases where splitting and disintegration occur too frequently, the child is liable to develop emotional problems, as seen in Danny's case. During the elaboration process's it had become obvious that Danny had aggressive fantasies toward himself and toward his parents. When his anger was channeled into the physical action of drumming, he was able to achieve better organization and sublimation. Still, a long period of working-through passed before Danny could gain some insight. Technically, Danny shifted his expression of splitting from the drums to other modalities, among which was drawings of his own self-image. First, he expressed "the bad me" (slide 1/slide 2) with the following explanation: "Me the wrecker. My eyes are shooting laser beams, my nose is sending a rocket and fire shoots out of my mouth". Four months latter he drew "the good me" (slide 3) and said: "I am a king with a crown and bright color's dresses". Though his self-image had begun to change and his behavior in school became less aggressive, Danny still suffered from isolation and lack of self-confidence regarding the role of his parents in his life. An example of this can be seen through guided imagery, when a musical piece

called “The Golden Voyage” elicited the following image: Mother eagle is flying in the air carrying her two babies on her back. (slide 4). He explained: “The picture is from the land of scribbles and dreams. The two babies and their mother are flying through the air, never able to descend to earth. At worst, if the chicks are tired they can rest on their mother’s back, that is if she agrees to slow down a bit”. Here Danny expressed his wish to descend to a safe place and his difficulty to accept his mother’s unpredictability. The Golden Voyage served as a facilitating factor to elicit and control fantasies.

Presented here was one of many examples of the phenomenon of splitting as appears in music therapy.

B. Healthy Gentle expression

In Danny’s case, I would like to illustrate his ability to express a gentle compassion, even during the period in which he was extremely aggressive. It gave me the feeling that within the Devil-Danny there was another Danny, compassionate yearning to love. An Angel-Danny. This happened during the same intake that Danny staged the war between the drum and the cymbal. After listening to his own recording, he improvised a “praising song” (2nd recorded example and).

The winning cymbal:

D. Yes, the cymbal won,

It won over the bad and that is that.

T. Your song is beautiful.

D. Many thanks.

T. And your voice is pretty.

D. So are the flowers (Intake).

Another example of tenderness was shown by 16 years old Gad, who was addicted to drugs and glue, and suffered from uncontrolled anger which caused him to perform dangerous actions. Gad had lost his mother and sister in a car accident while he was 9 years old. He remained in an ongoing pathological mourning and did not react to verbal therapy. His relationship with his father and the rest of the family were disastrous and at the age of 14 he began to experiment with drugs.

After half a year of hospitalization, Gad was released, tried to follow school but failed in almost all subjects, and was referred to music therapy by his psychiatrist. Indication for the relevance of this referral was as such: Gad drummed on every possible object, he was “addicted” to trance music and was even allowed to listen to this music with earphones during class. This fact reflected his teachers’ desperation. During our first meeting, he drummed the huge table drum to death. The drum beater was broken into 2 pieces and he then suddenly turned to the piano (which he never played before) and elicited a gentle, tender tune using both hands (3rd recorded example: [Gentle piano experiments after drumming](#)).

In music therapy, Gad and Danny both demonstrated an ability unknown to their environment: the capacity to be gentle and the wish to diminish the inside turmoil which dominated their lives. In both cases it was possible to move from aggressiveness to gentleness, as the drumming enabled a sublimatory outlet, paving the way to hidden, tender feelings. For the therapist, it is mostly a very precious moment of enlightenment.

C. Denial

As Anna Freud formulated it in her book: “The Ego and the Mechanism of Defense”, the task of the defense mechanism is to support the ego in coping with instinct anxiety, objective anxiety and conscious anxiety ([Anna Freud, 1977](#)). Anna Freud talks about the employment of denial in imaginative thinking. Indeed, children use denial in many ways, by transferring the origin of anxiety to something imaginative. This can be seen in the play of children, when they portray different roles, such as that of an animal, a hero etc. Denial can exist as long as it does not damage the ability to assess reality. When the ego matures and is unified by synthesis, there is no need to employ denial, unless there is a serious defect in the maturation process, as happens in psychosis. In the following example, we shall meet Didi, an energetic tiny girl, whose mother was killed in an extremely traumatic event, which left the family (father and 3 children) shocked and disheartened. At that time, Didi was 4 years old. Throughout the first months of music therapy, the child dedicated her time in running, dancing, singing jolly songs, laughing strangely, making sharp movements and resisting music that seemed sad to her. That is to say: she could stand only very quick, rhythmic music (4th recorded example: [text & melody improvised by Didi](#)).

A spring song

The flowers passed through the field
and clowns jumped on the sun.
Stars glitter at night
and the sun dances in the morning.
It is fun to be in the field, It is fun to be in the field
[be=live, be alive]
It is my nicest field:
Many flowers, arches, clouds
and very good rain.

For 2 months, her father stayed with her in the clinic (first inside and gradually outside the door) due to her enormous separation anxiety. Although Didi knew all the details concerning her mother's death, she refused to acknowledge the death emotionally and took care of eliminating and abolishing all signs of mourning.

After a few months, Didi, who had never before touched the huge drum, discovered its value and began creating a short drum-ceremony at the beginning of each session. This drumming, which was heavy and dramatic, continued ever since, unveiling a deep layer of bereavement and fear of death. At the same time 2 additional events helped bring about change in the usual pattern of denial: the war in Iraq and an illness that caused me to lose my voice for several weeks. Didi, as most children in our country who live in an unsafe and unstable environment, was again frightened to death and asked me: "Chava when are you going to get a heart attack and die?" This question opened the route to talk about her fears of losing her father, brother and sister, grandparents and all the people she cared for. I quote: "I was told once that young people do not die, but it is not true: my mother was young, Giora was just 25, children died around me. One can never know and it frightens me".

The loss of a parent influences child's development and self-confidence. This is specifically true when it occurs before their identity has been formed and before the image of the parent has been internalized. In addition, there is a danger that it will elicit anxiety and fear of recurrent losses before the child has learnt to cope with the concept of death and the dramatic changes that follow. As therapists, we ought to observe the surrounding environment and judge its capability to contain the child's anger and sadness. We should consider the child's social difficulties as well as the parents-child interaction which characterized the before-death situation.

Research shows us, that a child that experienced healthy, containing and supportive relationship, has a good likelihood of passing through the stages of bereavement and mentally rebuilding the lost parent's image (Silberman and Worden, 1992a). In our case, the mental presentation of the mother. In accordance with Bowlby's late theory (1969/1973/1980), in her choice of music, Didi first demonstrated the stage of shock and denial. Gradually, she passed on to a stage in which she musically experienced a healthy representation of frightening issues: how her mother was killed, how the Columbia shuttle with the Israeli pilot went down, medical pain treatment etc.

She experienced with these issues for several months till it became clear and less frightening. In her mother's last memorial day she was able to recite in the cemetery a song she composed over her dead mother.

Didi has a supportive family. This may be one of the reasons why her emotional process in therapy is developing in a natural way, including the denial period, which kept her safe for a while until she was ready to cope with her deepest fantasies and anxieties.

D. Rationalization

Raya lost her son many years ago in an accident during a time of war. In the first 2 years after his death she coped more or less with the situation though she showed less general motivation. Later, her husband passed away due to a terminal illness and she was left with her youngest son. At that point, her functioning deteriorated and she was treated psychologically and biologically. After a year, she was referred to music therapy by the psychiatrist of the place she had undergone 3 years of treatment at. Two years following the termination of MT she remarried a widower who brought his two daughters to the new family nest. Raya has undoubtedly rehabilitated her life. This is an outline of the story, but what had I observed through the intake process? An impressive woman, conservatively dressed, her movements somewhat sharp, her manner of talking was arrested and quiet, her Hebrew grammar perfect. Above all, she was very rational and careful not to exhibit any sign of weakness. She gave me few lectures in which she analyzed her psychological situation, almost professionally, but whenever she approached an emotional issue, she took care to circumvent it with mountains of rationalizing words.

In the case of Raya, at that time, both the past and the future were empty of content and the deficiency struck her and left her helpless. Rationalism worked for her as a

defense mechanism and it took half a year before she could say: “I feel most of the time as if I am tied up to a coffin, as if I am also lying in the grave unable to breath. I can not concentrate on my youngest son. Moreover, I even think that he does not need me”. This image opened a tiny window for working through, by exaggerating the feeling of suffocation and examining it in musical improvisations. Raya’s demeanor being so rigid, I suggested a simple improvisation on one note (5th recorded example: *Tied up in a coffin*). In this example, we can hear the E note serving Raya as an anchor and holding frame, enabling her to transmit and cast her own content safely: First monotonic and perhaps compulsive and gradually becoming more free and playsome. Play, in its most dynamic meaning as a creative component in our life and that did not exist even in Raya’s cooking. Throughout the years of therapy, Raya became creative and flexible in her musical expression, in her dance-movement and in her verbalization.

E. Passive-aggressiveness

There are many expressions of passive-aggressiveness observable in music therapy. I chose to show this phenomenon through the choice of the patients’ instruments: Jonas lost his mother through a long process of suffering, pain and helplessness, which soon manifested itself in passive-aggressiveness. During the years of his mother’s terminal condition, he was the naughty boy at home (from age 12 to age 16). He behaved as if mother was not lying there in severe pain, caused trouble in school, insulted his father, burned down his room and more. After his mother passed away, he became depressive, was expelled from school and from military service 2 years later. The army’s psychological service defined him as suffering from *borderline personality disorder*, but he refused to submit himself to psychological treatment and was eventually referred, first to art therapy, and then to music therapy. From the first stage of intake, he wanted to depict anger, not previously expressed, toward his dead mother who “was lying there like nothing, nerving the whole family.” He chose a small lyre to depict his anger, and asked me to represent his mother on the piano, commenting: “My mother was dominant even in her last month”. Indeed, during many months of music therapy, Jonas kept choosing the most delicate musical instruments I have in my clinic to express anger (such as dulcimer, Japanese bells, lyre, baby steel drum etc). Progress in freeing himself from the ambivalent position and the feelings of guilt toward his mother, occurred when he was ready to use his voice. Beginning with soft vocalization, he became more and more daring, until he was shouting and vomiting all over (6th recorded example).

Passive-aggressiveness describes a behavior pattern in which aggressiveness is expressed by passivity, rather than activity. It is typical of persons suffering from low self-esteem and afraid that open aggressiveness will bring about revenge and damage, or even destroy them (Reber, 1985: 547). No doubt, Jonas was afraid from the negative feelings he had toward his dead mother, which could neither be accepted by his family, nor his community and above all, by himself. He first had to openly experience these feelings in the safe container of music therapy, and only then cope with it in real life.

F. Obsession

I would like to present a short example of obsession as manifested itself in music therapy with Eric, a 40 year old schizophrenic patient in hospitalization. Eric showed many signs of obsessive-compulsive behavior. After two years of mute music therapy, during which he did not and probably could not utter a word, he gradually began to compose music and lyrics, after which he started to use his voice verbally and musically. His first song was divided into two sentences. After each, was a repeating sign with the number 20. Meaning, you have to repeat each sentence 20 times.

“Pathological symptoms as far as rhythm is concerned find their expression either in extreme pedantry or in extreme flexibility. In the first case this means compulsive repetition and perseverance, whereas in the second case this results in disorder, disorganization and incoherence. Examples of extreme pedantry can be found among neurotics who make use of rhythm as a defense mechanism, as well as with psychotics who tend to enter into movemental and rhythmic perseverance (Sekeles, 1996: 37).

G. Cutting short the rhythmical end of a sung sentence

This is a phenomenon I observed with schizophrenic patients and was recently informed that it exists also with other psychiatric patients (7th recorded example: *An Israeli song*). I spent a long time trying to understand the dynamics of this phenomenon, but could not find a satisfactory answer. However, Don, the patient you just heard, is a very musically-talented adolescent who plays from notes as well as

by ear and has no counting problems. He also realizes that he sometimes cuts short the end of sentences, but mostly he can not overcome it. It is obvious that the underlying problem is not musical, but rather psychological. It might be connected to the loose associations, flow of ideas and speech, that typify the schizophrenic patient and makes it difficult for him to stay grounded in the “here and now”. Indeed, many of them cut short also the end of the spoken sentences. (I would be interested to hear your opinion on this phenomenon).

Summary

In this presentation, I have attempted to offer a few of the many examples which describe and analyze phenomena of health and pathology, as they appears in music therapy sessions: Splitting – as expressed by a war between 2 musical instruments and by self portraits and paintings of the patient; denial – as expressed by the choice of cheerful, not threatening music in the sessions of an orphan child who lost her mother in a traumatic event; rationalization – as expressed by a woman in a mourning process who helped herself coping by verbally rationalizing every step; healthy gentle feelings – as expressed by an extremely aggressive children, who surprisingly chose to display their angelic sides in music therapy; passive-aggressiveness – as expressed by an adolescent who was frightened to show his anger toward his dead mother; obsession – as expressed in music by a chronic schizophrenic patient; and lastly: cutting short the rhythmical end of sung sentences in well known songs.

All the examples were in the domain of music and from my point of view, they reveal the analogy between musical events and the inner world of the patients. These analogies enable the music therapist to observe through music, diagnose, consider the therapeutic flow of the sessions and manage the treatment.

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CHAPTER 53

Deep sound therapy

Saloheimo, Raisa

,INTRODUCTION TO DEEP SOUND THERAPY

GENERAL

Where does the term "Deep sound therapy" come from? Iegor Reznikoff, Professor of Art and Music of Antiquity at the University of Paris, specialist in early music and especially and in particular the chant of Christian Antiquity, has been using the term since 1986 in his lectures and courses about the therapeutic influence of pure sound on various levels of human consciousness (advanced course of music therapy in Sibelius Academy).

To distinguish from the methodology used by speech therapists, I started to use the Finnish term "syvä ääniterapia" (a direct translation from the English term "deep sound therapy" used by Reznikoff in his lectures).

Early chants of Christian Antiquity are sung with deep voice and contemplation, but the technique also differs from the familiar western style in its relation to notes. In deep sound therapy we do not use the regular scale, but the natural scale where

also the body resonates. The natural scale is often used in old folk songs, hymns and in church service in liturgical songs. Even tango music, which has achieved popularity in Finland, shows some similarity with the early church liturgical chants (modes) in the intervals. This is my personal opinion and for example professor Reznikoff does not agree with this idea.

BACKGROUND

I first made contact with the chants of Christian Antiquity in professor Reznikoff's course in Sibelius Academy in 1987. Since then, I have used the methodology of deep sound therapy in music therapy and in lectures.

In 1989 to 1997 I mentored spring and autumn courses in Critical Academy of "The Experience and Understanding of pure Sound" together with Kirsti Autio, Tatjana Wilenius (in the start) and Hilikka-Liisa Vuori (a little later). I also used the methodology when I gave courses for vocational education students in music therapy in Sibelius Academy 1990 to 1999. At each elementary course in music therapy I give a lecture and have a workshop.

In the summers I attend the courses of professor Reznikoff.

Since spring 1998 I teach singing of Christian chants of Antiquity in the Chapel of Mathew (Matinkappeli) in the Parish of Olari in the city of Espoo every second Friday evening. Singing skills are not a prerequisite for participation in the group. The natural scale in these songs and the resonance of the body while singing them help and support the singers to find their voices anew. In the group we also make therapeutic exercises.

In May 1998 this group sang of the chants at a church service in the Killinmäki institution for mentally handicapped. We continued in the autumn and since then we have taken part in their church service once a month. I feel that the service has improved during these five years. The service was moved from the gym to the more imposing dining room and on April 10th 1997 bishop Eero Huovinen consecrated an altar on wheels for use at Killinmäki. With these improvements the amount of participants in the church services has tripled.

DEEP SOUND THERAPY FROM A RELIGIOUS PERSPECTIVE

THE WORK WITH CONFIRMATION CLASSES

I have used deep sound therapy in parishes first in Espoo and later in Helsinki when teaching chants and giving music therapy in confirmation classes for mentally handicapped.

Comparing with the other religious songs, the advance of deep sound therapy is the way it settle down the target group. The voice affect also for the most anxious participants of classes and the ability to learn and participate increase significantly. Since these songs represent the deep spiritual tradition of ancient Christian times, they are very physical ones – the voice resonates in whole body and attain thus better also the consciousness/mental levels.

"A" [a:] as in arm resounds in chest, above the sternum and the heart. "O" [o:] as in moore resonates most strongly in the throat and can be felt through the spinal cord up to the limbic centre of the brain. "U" [u:] as in mouth resonates mostly in the mouth. "M" resounds in the whole head and can be felt in the skeletal system of the body.

When you sing "A-O-U-M", the resonation starts from the chest, moves up to the throat and mouth ending in the head and above it. When you repeat it, the voice makes the resonation circulate in these areas and gives the singer "massage" from the inside. Breathing slows down and will automatically follow the rhythm during the song. The blood circulation and oxygen uptake in the brain and other parts of the body improves.

The syllable "OM"- is a holy syllable or mantra in Sanskrit and means God exist. "A" is included when breathing in and "U" as a phonetic addition. "A-O-U-M" is repeated peacefully.

The Christian "Amen" is phonetically similar and has a similar meaning, "So be it". Also the Jewish "Shalom" and the Islamic "Salaam" have the same kind of meaning. You wish peace with all your heart, speech and thoughts.

Singing is one of the best ways for severely mentally handicapped students in a confirmation class to get in touch music. Singing this way strongly resonating, they also make connection with the holy art of ancient Christian chants. In confirmation

classes and in the confirmation ceremony the atmosphere is very concentrated, sentimental and concrete and your eyes are often close to tears. I can feel how strongly the students take part in the ceremony. For many of them it is difficult or almost impossible to talk or understand conversation, but hearing songs and singing is another matter and they are able to sing or try to sing some words or syllables such as "Amen" or "OOOO".

In Christian Antiquity the chants were prayers based on Bible texts, for example the Psalms. These antiphons touch not only the body but also the spirit and the soul – all levels of consciousness. In his early lectures Professor Reznikoff mentioned four levels of consciousness: Superficial, Medium, Deep and Divine consciousness. The best way to pass on the Christian message, the prayers, to mentally handicapped is the chants of Christian Antiquity.

The impact of this kind of songs surprises and delights me again and again. And not only do they impress the students, but also me and the other attendees.

I can remember when I was at a concert by Professor Reznikoff for the first time. It was held in the church of Olaus Petri in Helsinki at the end of the course in February 1987. The winter afternoon was turning to evening and the church was lit only by candles. The song of Professor Reznikoff resounded and resonated in the darkness of the church. Sitting on the pew I felt somewhere between staying awake and falling asleep, but I still felt physically present. "My soul and my spirit was resting", and I can imagine that singers of Psalms through the ages have had a similar kind of experience.

My Father was a member of the Finnish Orthodox Church and often took me with him to follow the liturgy. My mother gave me a Lutheran education. When I was in the confirmation class I considered to convert, but I decided to stay Lutheran. Due to my background I am ecumenical.

SERVICE

The Ancient Christian chants add a special and strong influence to the divine service. These chants were an important part of services in the early Christian church. The message sticks better when it is sung since the song passes through both sides of the brain and activates wider parts of it than the spoken word. The aphasics are good example of this; they are able to sing some old familiar songs accurately even though they cannot speak. The songs and the melody also help to understand speech (= melody intonation therapy). The songs in natural scale (human body resonates in natural scale) penetrates the different levels of human consciousness better than songs with western scale (temperated scale). To pray in a singing voice

touches more deeply and calms one down. You get connection with your holy inmost. I do not know any other way that has such a so strong impact. This kind of song is a holy art. It takes care of not only the audience but also the singer herself.

We sang the Sanctus hymn at a church service in Killinmäki. One part of the group sang the borduna (the base note) and the other sang the melody. After the service the priest and the cantor where surprised by the strong physical impact of the songs. The priest said that he felt a resonation in his chest he had never experienced before. They did not sing themselves, but listened to the hymn of the holy trinity performed by our group (the deep sound group). We have sung in other services too, not just for mentally handicapped. The impact is always the same. It soothes the listeners.

In Matinkappeli we have a "church service time" once a month carried out by the laymen but following the liturgical form, except for the sermon or Holy Communion since there is no priest. In these ceremonies either I , or a part of my group, sings the antiphon that is appropriate with the topic of the ecclesiastical year.

Relatives of a departed mentally handicapped asked me to play zither and sing the songs, which were familiar from the confirmation class of the deceased about five years earlier. The ceremony was unique. Even though it was a stormy spring afternoon, the sun was shining on the casket just during the ceremony. The atmosphere was cordial and overarching. The presence of Holy was felt.

HOSPICE/TERMINAL CARE – ALLEVIATION OF PAIN

Deep sound therapy eases the condition of dying persons in many ways. For example, a person in coma can hear the voices which penetrates all levels of the consciousness.

I will give an example of a man who was in a terminal care last spring. He was falling into coma and the nurses asked his relatives to come to say farewells. However, his sister could not make it there before he was in coma. The relatives and the priest asked me to sing for the dying man. I took my zither and we approached his bed. The dying man's wife asked us to sing a familiar hymn. I played my zither and sang together with the wife. Suddenly the man coughed, opened his eyes and started to sing with us. Then we sang the familiar hymn "Mun kanteleeni kauniimmin" and he waked up again and joined us in the song. He was also able to talk with his wife and

sister. The doctor of our department was amazed: –"What has happened, he is supposed to be dead". The doctor asked the man in the sickbed if he would like to have something to eat but the man answered that he was not hungry. The relatives were astonished too, but happy to get to talk with the man once more. The pastor of our hospital said it was a miracle and very significant for relatives that he "waked up". He lived one week after this event and had a peaceful departure.

The songs offer many dying people relief. A familiar hymn takes the thoughts away from the painful and depressing feelings. A beautiful and restful song concentrates the thoughts by consolation of the word (compare the idea of singing versus talking mentioned earlier). Songs in natural scale (that is most of the hymns and many other religious songs) affect also physically by resonating the body. The pioneer of music therapy in Finland, psychologist and music therapist Petri Lehtikainen, has developed the so called physioacoustic therapy which utilises low frequency sine waves to reduce stress and muscular pain. Originally the idea comes from the strong relaxing impact of music on the human body. One can say that the physioacoustic or vibrational energy treatment is like a machine massage and deep sound therapy is a manual massage.

A 40 year old woman had breast cancer. It was operated and she received cytostatic treatment and radiotherapy. After a couple of months the cancer had extended to her brain and lungs. The cytostatic treatment was discontinued and she was told she had a couple of months or maybe half a year left to live. She was transferred to the health centre's ward for terminal care. I met her in the emergency department where the doctor asked my consultation, thinking about music therapy. I went to her room where she was lying in her bed. The doctor and the assisting nurse were also there to follow the situation. The problem with her was occasional anxiety and confusion. After saying hello, I started to sing to her with a deep voice. She calmed down immediately, shut her eyes and looked as if she had fallen asleep. After five minutes of singing we left the room. The doctor was instantly convinced of the necessity of music therapy. Later the patient was transferred to a hospital nearer to my place and it was easier for me to help her daily. The second time I saw her she had a bright moment and told me what she had experienced when the first time we met. She remembered how I had sung for her and asked for more. She also told about her children and how difficult it was to part from her youngest, ten year old son. I recommended discussions with our hospital priest. In the following months she was occasionally confused and fastened to the chair or bed due to safety reasons when the staff was not available. I met her regularly, almost daily, and our hospital priest had discussions with her. Deep sound therapy always calmed her down and made her obviously relaxed. I also met her relatives and friends and they were grateful for the treatment. Obviously the terminal care of such a person is hard for

the nurses and other staff, many of them were of same age as the dying woman or even younger. Her energy diminished gradually and she died peacefully with her relatives gathered around her. Deep sound therapy did offer help, along with sufficient medical treatment.

When my husband was in his deathbed in coma, he reacted strongly to noise. The noise from a landing field for helicopters near the cancer clinic caused him painful feelings. One night when he suffered from the noise it was replaced by the classical aria in Händel's *Rinaldo* on the radio. The music had an instant effect and he calmed down. My husband loved Händel's music and used to listen to it often when he was healthy.

Why does deep sound therapy affect so strongly? Deep sound penetrates deep into human body. For example, the singing of "OOOOOO" affects through the spinal cord on the limbic system of the brain and the hypothalamus and from there on the autonomic, previously named vegetative, nervous system.

"The autonomic nervous system is part of the peripheral nervous system, which controls the smooth muscle tissue, the heart and the glands. It is also named the unintentional nervous system.

The hypothalamus activates the sympathetic nervous system, for example in physical or corporal work, in dangerous situations, strong emotional feelings and other kind of stressful situations. The limbic system connects the autonomic nervous system with emotional experiences"(1). Hence songs calm down and balance nerves and brain. The effect can be strong enough to make an epileptic fit disappear. I have had several experiences about this in my practice. An epileptic fit is a malfunction of the brain and sound, specially the "OOOOO" makes it stop.

Deep sound therapy even has cumulative effect on some people. One singer in my group suffered from severe epilepsy. She sang in the group, one and a half hour about every second week. Later on she told me that after one of these singing sessions she had no epileptic fit for even two weeks. Naturally, she had medical treatment as well.

AUTISM AND THE USE OF DEEP SOUND THERAPY

For about nine years in the 1990s I rehabilitated children who were diagnosed autistic. Deep sound therapy offers the best possibilities to get good results. Music as such is pleasing for most of the children. Deep sound therapy made it possible to get contact with them and to get a message through by singing.

One child immediately stopped walking around and stood still when I started singing. He stayed almost frozen and stared at me, probably wondering where the voice came from.

Most children had very sensitive hearing, which caused them difficult situations. For example, the noise from the air conditioning might sound as the noise from the a jet plane and cause even insufferable pain. In order to achieve successful therapy the room had to be emptied from all extra things.

For many of the children diagnosed with autism the visual messages and visual perception offers the base for assessment of the situation. They do not necessarily understand spoken language. Therefore I use visual hints such as pictures of situations, items and actions to illustrate the daily routines from their point of view (so called pictos). The music therapy is also divided in separate themes with the help of the pictures. Clear start, intermediate phase and end state. In order to achieve relaxation in the end state I used deep sound therapy. At the start I sang each name in natural scale (for example "Is Maija here" in the melody of the hymn Hosanna filio), and they answered in there own way, even singing or playing some rhythm instrument. I was called "Auntie OO" by one kid, which described well the matter I was representing.

I observed obvious progress in interaction skills, concentration capabilities and communication skills. The children's taste of music also expanded. For example, one girl who was in my rehabilitation four years unexpectedly took a CD disc and started to listen. Her mother wondered what her daughter was listening to with earphones and noticed that it was one of Sibelius symphonies The girl enjoyed that CD for a long time. Before that her only music used to be children's songs. Her capability to tolerate different kind of sound improved. Her learning improved the longer the rehabilitation continued. Special features of her behaviour did not disappeared, but they did not disturb as much as earlier.

The aim with most of the children were to get them into dialogue, to communicate, concentrate and express themselves. We also tried to develop social skills. Earlier, about 10–20 years ago, there was a view that autism is an early disturbance in the child–mother relationship, but that view has later been proved wrong. Autism is a serious neurological problem which can not be cured with traditional psychotherapy. Because of this neurological background, music therapy and specially deep sound therapy are good rehabilitation methods. Mentors with psychotherapeutic background said that autistic children have no social contact skills. I think it is wrong to think that way, because my experience of working with them tells me quite different. The traditional music therapists rehabilitated earlier autistic children only with individual therapy, very seldom in groups. In the 1970's Juliette Alvin and Auriel Warwick in their book "Music therapy with autistic children" (translated by Kari Riikkilä 1995) reported only of situations where the music therapist and child were working together. In some cases the child's mother joined in the therapy after a while.

I always started the music therapy with autistic children in a group because their problems mostly appear in group situations and that is why it's better to start the therapy in a group. Very seldom I had individual therapy with them, only with a strong reason, for example a difficult behaviour problem such as aggression against to other members of the group. Then I worked with them individually but the goal was always to get them back in the group.

This same mechanism explains the behaviour of an autistic person during deep sound therapy. The sounds are directly connected with the autistic persons world because. Words can for example be more easily understood when melody is added. The spoken language does not penetrate the consciousness of the autistic person ("Taide psykososiaalisen työn välineenä", pages 143–144, edited by Heidi Ahonen-Eerikäinen). Temple Grandin, who is an autistic person herself, mentions in her book "Out of autism" how decisive all communications therapies such as speech and music therapy was to her. I mentioned above the neurological influence on the limbic system of nerves and hypothalamus. In their book *Neurology* (page 52) the authors Jorma Palo, Matti Jokelainen, Markku Kaste, Heikki Teräväinen and Olli Valtimo shows a picture of the structure of the autonomic nervous system.

Also in Parkinson's disease deep sound therapy calms down and relaxes with remarkable effect on the forced movements the patient is suffering from.

I have tried to give a picture of the use deep sound therapy with some examples so that the reader can get a better view about what it is like working with autistic children with difficulties in communication and behaviour. There are very few books

about this problem. However I have got support from T.E.A.C.C.H.(Treatment and education of autistic and related communication handicapped children), a method I learned and from psychologist Tuula Kulomäki in the Autism Unit, who mentored in our team. Working with autistic children themselves gave me the best knowledge. When I became acquainted with their world, how they see it, it was a very learning and interesting experience. It was amazing how much curiosity, patience and toleration the showed the music therapist who was quite lost every now and then.

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I am very grateful to Professor Iegor Reznikoff for his numerous lectures and courses where I have got an opportunity to learn DEEP UNDERSTANDING AND EXPERIENCE OF SOUND. Partly, I could use his method quite direct, but I have also developed it with my own point of views. Most I rejoice that Christian chants of Antiquity have enthused so many people in Finland to sing and learn these songs.

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CHAPTER 54

*The development of a schools music
therapy service with an illustrative*

*case study of work with
a child with Autism*

Storey, Jo

This paper was presented at the 6th European Music Therapy Congress in Finland in June 2004. It was illustrated with video extracts, and for the purpose of this paper I shall write a description of the extracts.

Introduction – Music Therapy in Cambridgeshire Schools

I would like to begin this paper with an over-view of how music therapy came to be established in schools in Cambridgeshire, UK. Within the paper I am also going to present aspects of music therapy work in schools, illustrated by a case study of work with a boy with autism.

In 1995 there was no organised system for music therapy in schools in Cambridgeshire, and very little practical work in existence. Amelia Oldfield was working with pre-school children at the Child Development Centre at Addenbrookes Hospital and with school-aged children at the Croft Children's Unit, but there was hardly any music therapy provision in schools.

At this time the first intake of music therapy students completed their training at Anglia Polytechnic University, and Helen Odell-Miller and Amelia Oldfield (the course leaders) had initial discussions with Martin Gent (then head of Cambridgeshire Instrumental Music Agency) about the possibility of setting up music therapy in schools. The Cambridgeshire Instrumental Music Agency (CIMA) was responsible for supplying peripatetic instrumental teachers to mainstream schools in the area, but had not previously had any links with music therapy. Martin Gent consequently wrote to all the special schools in the area and there was considerable interest in this. Initially CIMA took on three music therapists to cover a few hours here and there in a variety of special schools.

Over the last nine years the team has expanded to 8 music therapists working in a number of different special needs and mainstream schools. Generally the work has developed by music therapists starting off working for a few hours in each school, and once the school becomes convinced that music therapy is effective and therefore essential, they expand the hours (and somehow manage to find the money in their restricted budgets....!) This has happened in virtually every school that CIMA music therapists have worked in.

There have been many advantages to the creation of an organised system of music therapy provision in the county, in conjunction with CIMA. At the out-set we were able to set up a Service Level Agreement, which presented the needs of the schools and also the working requirements for music therapists, for example, instrument and room provision, the need to have breaks between sessions for writing up notes, and so on. This meant that music therapists setting up work in schools had these guide-lines to work from, and both schools and therapists had similar expectations for the organisation of the work. In addition to this, a fair system of pay and travelling expenses was established. Music therapists are paid on a percentage salary by CIMA according to the number of hours they work per week. The schools put in an order for the quantity of music therapy hours they require for each academic year.

It has been exciting to see the team developing and evolving over the years. Being under the CIMA “umbrella” has meant that the work has remained consistently organised, and that we have met regularly as a team, both to discuss work issues and socially. This has avoided the isolation that music therapists can experience when travelling around from school to school. CIMA has provided funding for in-service training days, and we have been able to consider each team members professional development.

Fitting into the school context

I feel that our main strength as a music therapy team has been the capacity to be flexible and adaptable in relation to each different school environment. Some schools have been extremely limited in terms of providing a space for therapists to work in. In this case we have taken the approach that we can work for a short period of time in a space which may not be ideal. Once positive relationships with staff and children at the school have become established it has then become possible to suggest the need for a more appropriate working space. In our experience it has been better to work in this way in conjunction with the school, than to immediately demand the impossible! Generally if schools have the experience of a therapist working on site they become aware of the requirements of the therapist, in terms of space and instrument provision, over a period of time. The essential factor has always been positive communication with staff at the school.

To quote from Leslie Bunt and Sarah Hoskyn’s book “The Handbook of Music Therapy”(2002):

“Several authorities in the UK employ music therapists.....The settings where children are seen for therapy vary from dedicated spaces in music therapy centres to shared spaces in pre-school nurseries and rooms of varying quality in schools. The provision of suitable space for therapy is usually improved when there is a clear explanation about the work and close liaison between the visiting music therapist and other staff in these settings.”

Every four years schools in the UK have to undergo a schools inspection by Ofsted inspectors. These inspectors took over the role of schools inspections about 9 years ago. Music therapists working in the school context have to communicate with the inspectors about their work, and on occasion, provide music therapy sessions for observation. In my experience this has been a surprisingly positive experience, despite my initial reservations...! In all three inspections I have experienced, the inspectors have pre-arranged some appropriate music therapy observation and have been very sensitive to the nature of our work. The last time an Ofsted inspector observed a session it culminated in positive feed-back within the schools report, and this in turn led to an expansion of my hours at the school. The inspector had not previously observed any music therapy but was a musician, and appreciated the powerful effect of music on the children!

I should probably discuss the difficulties of setting up work as well as our positive experiences..... It is hard to go into a school where music therapy has not previously been established. Colleagues at schools can be very suspicious of “therapy” and there may also be jealousy of the fact that we have the opportunity to work one-to-one with a child. Again we have found that honesty and openness is the best policy. Talks for staff and sharing video material (where appropriate) can enable colleagues to understand the work, and to view it in a positive light. We aim to work as part of a team within each of the schools, even when working for just a few hours in each school. The more discussion of work with staff that takes place, the more this is possible. Regular meetings with teachers, learning support staff and other therapists are essential as a means of sharing information about children and facilitating a team approach.

Auriel Warwick(1995) described the need for communication with staff in schools in her chapter on the development of music therapy in education in Oxfordshire:

“Music therapists must take on the responsibility for dispelling...suspicion and anxieties by being open about their aims and methods: talking in seminars to colleagues in schools, school governors, running workshops and presenting videos of individual and group work with children so that the value of the therapy can be seen in the context of the whole curriculum for the child.”

We have found that this positive type of publicity, promoting understanding about music therapy has been invaluable.

We regularly have music therapy students from Anglia Polytechnic University on placement at the schools and provide suitable music therapy sessions for students to observe, as well as setting up case work for them. The little boy, Christopher, I would like to discuss had music therapy sessions with a music therapy student, Ioanna Etmektoglou, for two months, prior to my commencing work with him. Ioanna was on placement with me at Green Hedges School during this time. She observed some of my work over this period and carried out her own case work. I supervised some of her case work, and this provided me with information as to how children were progressing in sessions. There was also valuable dialogue between Ioanna and the class teachers and learning support assistants.

Case Study - Christopher

Christopher was six years old and had a diagnosis of autism. He had a history of tantrums and challenging behaviour in relation to feeling a loss of control, and also limited communication and no speech when I first met him. He was a child who I feel particularly benefited from having music therapy within his school environment. He was bright and alert, but had extreme problems with dealing with new or unpredictable environments which he felt were beyond his control. By first becoming familiar with his class room setting, he was able to build up his confidence to moving to the music therapy environment within a relatively short period of time. The music therapy room was just down the corridor from the class, and it was therefore not too traumatic for Christopher to make the move to this space. Had he had to travel somewhere else for the sessions it would have been much more disruptive.

Christopher initially presented as a very nervous child who needed to literally cling on to things for support. He was desperately in need of reassurance both in and out of music therapy sessions. However, during his 2 months of sessions with Ioanna it became clear that he was very responsive and sensitised to sound and music. Through his interest in the musical instruments his confidence began to increase, and he would sit very close to Ioanna, tentatively exploring the instruments. Ioanna's gentle and calm manner enabled Christopher to feel relatively secure within the music therapy environment, and she introduced him to some new songs, playing along quietly with smaller musical instruments. At the end of this phase of

therapy Christopher had built a positive relationship with Ioanna based on the shared experience of quiet playing and singing together.

Ioanna was keen for Christopher to continue to have music therapy after she finished her placement, and I resumed music therapy with him the following September(2001).

One of the points that Ioanna and I discussed in relation to Christopher's sessions was his love of familiar song material and the structure that this provided for the music therapy. The first video extract I presented was of me singing a hello song with Christopher which provided this element of structure and preparation for the start of the session.

The video extracts were taken from a session after I had been working with Christopher for a year and a half. By this time he was taking a relatively confident approach to playing and exploring the instruments, and was also enjoying using his voice.

For the first year of sessions Christopher used to just listen to the "Hello" song, but as his confidence with his singing and vocalising developed he became able to sing along with me. In the extract Christopher was extremely engaged in the content and familiarity of the song, and put his head down to listen at the same time as vocalising along. His vocalising was tuneful and consistent, and became increasingly confident as the song progressed. This reflected Christopher's developing confidence in the use of his voice in music therapy, but also in other contexts.

In the video extract you could see Christopher pressing down the piano keys repeatedly and this seemed to add to his sense of control. Christopher often did this when I was accompanying him on the piano. At times he would hold the ocean drum in one hand, and press the piano keys with the other.

Christopher was generally avoiding eye contact even though he was totally absorbed into the shared singing experience. In fact, the most sustained eye contact he used was generally in response to a sudden change in pitch or rhythm, so I was able to use this to encourage a more consistent exchange of eye contact.

Another aspect of working in a school is the need to have an awareness of the child's experiences in the class setting. At Green Hedges School, where I am based, they use a structured approach to working with children with autism, called the TEACCH method. This is a system whereby the child is very involved in the structure of the day. He/she will have a time-table with symbols or words for each activ-

ity during the day. With this system, the child becomes prepared for changes in activity or environment, and therefore is less traumatised by these things. Each child I work with will have a symbol or picture for music therapy on his/her timetable for the day on which I see them. As well as engaging in this process, I often feel the need to incorporate an element of structure into the session itself, to help the child utilise the session with the minimum of stress. It is possible to create space for expression and spontaneity within a secure structure. Christopher was a child who needed structure within sessions, and would have found it very difficult to participate in the playing without this reassurance. With a predictable structure it was possible to draw Christopher into expressive shared playing and singing, which would have been too threatening without this safety net.

As I have discussed, the links with staff and parents at the school has been an important part of my work. I received a lot of information about Christopher's development in other situations from staff at the school and also from his mother. Christopher's mother was delighted that he would be receiving music therapy at the school and was keen to discuss his development in sessions. She was able to inform me of his progress at home, particularly in relation to his use of his voice.

The next video extract was of Christopher and I engaging in shared singing and playing on the "frog" castanets. This was a song that Christopher and I had shared many times in sessions, and one that he enjoyed very much. It began with me singing with the frog scrapers and him playing along on the scraper too. Gradually he started to vocalise and this evolved over a period of months to him vocalising increasingly tunefully and then attempting to annunciate the words with the tune. In the extract you could see Christopher looking around the room, constantly checking out his environment and making sure things were "safe". At the same time he was remarkably involved in the music making process and sharing in the song material with me.

Through discussion with Christopher's class teacher I established that he was using his voice increasingly confidently in the class room setting, and beginning to participate in group singing activities. I showed these video excerpts to Christopher's class teacher and she was extremely impressed with the comparative confidence with which he used his voice in the music therapy room. This gave me feed-back on his vocal development in the class setting, but also enlightened the teacher as to the type of interaction that we were having in music therapy.

Christopher's need to control his environment became apparent soon on. I had a guitar in the corner of the room which was leant against the piano. One day Christopher came into the room and immediately began screaming and pointing to the

instrument. I realised that the angle that the guitar was leaning at was slightly different to the week before. I moved the guitar out of the room and Christopher relaxed straight away. After discussion with his class teacher I decided to have the guitar back in the room for the next session. It transpired that the policy with Christopher's adverse reactions to things was to try and enable him to face up to objects or the placing of objects, even if they initially upset him. Sure enough, the next session he became very upset on seeing the guitar and had a tantrum for about 5 minutes. After this, he settled down and became focused on gentle playing on the shakers and drum, giving an occasional sob when he looked over at the guitar. The following week Christopher hardly noticed the guitar, and just ignored it. Over a period of weeks I managed to acclimatise him to the guitar, picking it up for a few minutes, and then putting it down when he became distressed.

After about a year of this, in weekly sessions, Christopher decided that he would like to play the guitar. He gradually put his hand closer and closer to the guitar strings, and eventually began strumming them gently. After a few weeks of this, he began to go and get the guitar at the same point in each session. He always gave me a triumphant grin when presenting the guitar to me. Over time I managed to establish some singing with the guitar which he enjoyed, and he was then able to relax and appreciate the sounds.

In the video extract you could see Christopher enjoying shared singing and playing with the guitar. His concentration was excellent and he was able to predict the ends of phrases to songs. Christopher put his hand out to control my playing from time to time, and this enhanced his sense of security within the interaction.

A very exciting development with Christopher's sessions was his use of his voice. He was verbally silent for the first few months of sessions, but always indicated to me that he enjoyed singing activities. Gradually he began to use his voice to make demands or respond to requests, making tuneful sounding "Hmm" or "Agah" vocal noises. As he became familiar with various songs that I sang to him, he began to vocalise along to them. This happened very gradually over a prolonged period of time. First of all his responses were tuneful and he began to imitate the pitch of my singing. Then he began to attempt to formulate the words as well as the pitch, making exaggerated confident mouth movements. Around this time Christopher's mum informed me that he was beginning to sing to himself in his bedroom at home. He was more reluctant to sing when other people were with him, but he would sing to himself in bed! This gradually spread into other situations, and he began singing to his grandmother down the phone. Christopher's mother now uses singing to calm him when he has adverse reactions to situations, and they also engage in some shared singing together.

Christopher also became increasingly consistent and confident in his use of eye contact and gestures in order to communicate his needs.

Another area in which I discussed Christopher's development with his mother and class teacher was his capacity to listen and concentrate on exchanges. Initially he was very easily distracted by his general levels of nervousness in relation to the environment.

In the next video extract you could see Christopher engaging in playing on the wood sticks, but also his listening ability. He began with confident, rhythmical playing and then his playing diminished by his need to listen to my flute playing. You could see in the video extract that I tried to keep Christopher engaged in the music making by continuing to play even when he stopped. Through using this method his playing in other situations became more sustained. When he stopped playing Christopher still appeared to be listening, and made very direct eye contact as I finished the last phrase of my flute playing.

Christopher enjoyed choosing something to play good-bye on to prepare for the end of the session. In the next video extract he selected the wooden octachime. He initially played in a typically "autistic" type of way, focusing in on the physical elements of the musical instrument. We had a turn-taking structure for this activity, and when I had my turn I played in a more lively manner, but incorporated aspects of his approach to the playing. In this way I accepted his way of playing but also encouraged him to develop and expand his approach. When he had his second turn he was able to develop a freer style of playing, with some imitative elements of my contribution. This indicated that he was not "stuck" into an autistic type of play but was able to incorporate my ideas as well as retaining his own individual style.

Conclusion

Christopher's music therapy sessions provided him with a space in which to explore interactive and expressive playing in a secure environment, and to develop a confident and communicative approach to shared vocalising and singing. This led on to him being able to use his voice confidently and competently in other situations.

Christopher is just one example of a child who has benefited from having music therapy in his school environment. I haven't had time to give examples of other children or other styles of my work at the school, but the possibilities for music

therapy in this context are boundless. Within any special school the children have such a diversity of needs, and music making within a therapeutic context can be used to address these varying needs.

The case-study of Christopher high-lights the importance of music therapy being accessible to children within their school environment. Once children are established in a school setting it becomes difficult to incorporate music therapy sessions into the child's routine, unless the music therapist is available on site at the school. This is not only on the practical level of getting the child to the music therapist, but also taking account of the anxiety involved in the process of getting the child to a new place. There are increasingly high proportions of children with autistic spectrum disorder in special schools, and a large number of these children find going to new places a terrifying experience. By providing therapy on site at special and mainstream schools, children can learn to deal with the new therapy environment in a situation which is adjacent to their familiar school setting.

The possibilities of communication with staff and parents of children at the school greatly enhance the quality of the music therapy work, and as I have described, there are countless advantages to the therapist being able to integrate as part of the staff team.

Fortunately many schools in Cambridgeshire have risen to the challenge of securing funding for music therapy, and we hope that the team of music therapists working in schools in our county will continue to increase. I would also be delighted to see other county music services taking music therapy under their wing, so that the provision of music therapy in schools in the UK could become more evenly distributed and consistently organised.

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CHAPTER 55

*Time limitation in psycho-dynamic
music therapy - a focal music
therapy concept (FMT)*

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Introduction

Nowadays the general duration of a therapy is predominantly determined by economical aspects. This means as short as possible, according to the motto: time is money. Many music therapists have to deal with a treatment that lasts for a few weeks or a few months only. This often results from time restrictions defined by the national health services already at the beginning of the therapy.

In addition to this more and more clients themselves expect a prompt improvement of a single well described problem. From a psychodynamic point of view, one has to be very sceptical about such attitudes because the therapeutic concept is based on exploration, understanding and insight. These principles imply the necessity of having enough time.

Also musictherapeutical principles are usually associated with long term perspectives. They are closely linked with preverbal experiences and developmental pro-

cesses which also need enough time. Hence, we have to answer the questions of how we can deal with these contradictory aspects and for which clients such a concept can be of any help.

Asking this crucial question I was driven to develop a concept which does not only consider the psychodynamic principles of musictherapy but also the demands of a short time therapy. I am personally motivated through my work of the last 20 years at the department of rehabilitation in the psychiatric Hospital in Vienna (a specific therapeutic department without any regional restrictions of the patients being there).

The diagnoses/indications of the inward patients are psychoses, borderline and personality disorders. Relapse with auto aggressive behaviour, chronic course or even suicides are a permanent risk for most of the patients. The average amount of the inward treatment is 3 to 5 months, the most frequent amount of sessions is between 11 and 25 hours:

TABLE 1. Music Therapy at the Department of Rehabilitation

| | |
|--|--|
| 1 – 10 hours = 22,7 % 11 - 25 hours = 63,6 % 26 – 40 hours = 13,7 % | 45 % schizophrenic psychosis 41 % borderline -disorder; eating disorder 14 % depression, manic depression, personality disorder |
| 56,8 % male 43,2 % female | 18 % group music therapy 82 % individual music therapy |

As we can see on the table the percentage of patients who take part in individual music therapy sessions is quite high. This fact and the above mentioned circumstances have asked for a musictherapeutical short term concept for individual therapy. Therefore I have developed a concept called: focal music therapy.

For me, one of the most important parts was to integrate my approach - the psycho-analytically informed music therapy - and the existing concept of a systemic, aimoriented treatment strategy of the department where I am working. Nevertheless inpatient work is almost all the time confronted with time restrictions.

I have chosen a methodology which has already proven right within music therapy that is to say the hermeneutical approach which I am going to outline in the following paragraphs.

Nowadays it is common sense to integrate psychotherapeutical models into musictherapeutical concepts. This means that musictherapeutical principles are being deduced from the principles of psychotherapeutical models and that they are being explained and modified on their fundamental believes. And this is exactly what I did in developing this focal concept. I linked the theories of the psychodynamic short term psychotherapy with the musictherapeutical theory of "specific doing".

A very prominent role plays the "Psychodynamic Short Term Psychotherapy" by Strupp & Binder. (Both are American psychoanalysts and psychiatrists with a long lasting clinical experience.) Their concept is based on the original assumptions of the psychoanalytical short term therapy and also involves the needs of psychiatric patients.

The now discussed focal music therapy concept has been developed in 3 main steps mainly based on Strupp & Binder's approach. The first step was to identify the basic principles of therapy. The next step was to make out the described principles in the psychoanalytical informed musictherapeutical literature. And the last and most important part was to link these principles and to translate them into musictherapeutical interactions.

But before we go into details of this focal concept it is important to outline the sense and understanding of the general psychodynamic approach within musictherapeutical work and to give you a brief overview of the historical development of time limited dynamic psychotherapy.

The general psychodynamic approach

Psychodynamic is the basic model to explain psychological experiences in the psychoanalysis resulting from a dysfunctional drive development which has its origin in deficits during childhood. The psychic processes are formed by the play of the different psychic forces which work together to support, to suppress, to combine, to conflict or to compromise with each other.

Knowing this it is possible to understand the intrapsychic patterns of conflicts appearing during the musictherapeutical improvisation (resulting from common creative processes).

Therefore it is always the aim of psychodynamic oriented musictherapy to discover the structure of conflicts. In order to understand the past and the pattern of conflicts it is important to understand the structure of the intrapsychic processes, the phenomenon of transference and counter-transference, the defence and resistance. These are some of the general principles which play a dominant role in every psychodynamic work and which are of course part of the FMT concept.

Historical background of the psychoanalytical short term therapy

It is interesting that the literature of psychoanalytical short term therapy refers to famous musicians. Bruno Walter¹ for example who asked Freud to care for his neurotic paralysis of his arm and which Freud should have treated in 6 sessions.

Another one was Gustav Mahler who also went to Freud and whose treatment took four hours in one session only.² This fact – Freud's partial interest in a kind of brief therapy at that time is an interesting fact insofar as Freud had to justify the increase of treatment duration at the same time (which was caused by changing the technique: analysis of resistance and transference).

As a reaction to this tendency Sandor Ferenczi and Otto Rank tried to shorten the length of the whole treatment. They did so by limiting time and intensifying the affectivity in the countertransference through establishing the "Active Technique".

1. Walter, Bruno. "Thema und Variationen." Frankfurt a. M.: S. Fischer, 1947: 212–216.

2. For Mahler's and Stekel's treatments look Weghaupt 1998: 197.

TABLE 2. Historical background

| The Beginning of Time Limited Psychotherapy | | | |
|--|---|--|---|
| | Proponents | Motivation | Method |
| 1920's | Ferenczi, Rank | Shortening the psychoanalysis to a more flexible treatment | „Active Technique“ |
| 1940's | Alexander , French | Shortening the psychoanalysis to a more economic treatment ∅ a focused therapy for traumatized soldiers | „Correcting emotional experience by regulating measures“ |
| 1950's 1960's | Balint, Ornstein, Ornstein and Malan | Independent short term psycho - therapy concept: 'The Focal Therapy' for a more economic treatment | Mobilization of a conflict through the focus |

As we can see Sandor Ferenczi and Otto Rank had been one of the pioneers and afterwards Thomas French and Franz Alexander from the States (USA) took up this initiative again whereas their motivation was to develop a proper concept especially to treat traumatized soldiers.

Michael Balint and the English Group have for the first time developed a concept for short term therapy on its own in contrary of shortening psychoanalysis. Afterwards a lot of different concepts have been developed since than. 5 of which I'd like to outline quite shortly.

TABLE 3. Psychodynamic Short Term Therapy Concepts

| Psychodynamic Short Term Therapy Concepts | |
|--|---|
| Some Examples | |
| Balint, Ornstein, Malan & Ornstein [ca 20 h] | Linking interpretations between transference experiences and family constellations in the childhood |
| H. Davanloo [ca 15 -30 h] | Working on resistance and interpretation referring to early family constellation |
| P. Sifneos [ca 12 -15 h] | Defining an oedipal focus. The countertransference is meant as a disruptive factor. |
| J. Mann [12 h] | Emotional conflicts as a result of the fight between unconscious desire for endless love and care and the knowing about finiteness |
| Strupp & Binder [ca 25 h] | Defining a dynamic focus: Transference r elation Actual life situation Life history |

And we are going directly to the psychodynamic short term therapy of Hans Strupp & Jeffry L. Binder and the question: Why exactly do I refer to their concept?

TABLE 4. Strupp & Binder: The Psychodynamic Short Term Therapy

| | |
|---------------------------------|--|
| Motivation: | <ul style="list-style-type: none">- A meaningful concept for more patients- A concept for patients with heavy ego function disorders |
| Main Characteristics: | <ul style="list-style-type: none">- In the middle of interest: the transference relation- The question: how do behaviour patterns, resulting from early experiences influence actual relationships- On this basis a dynamic focus is formulated- Hypothesis: actual emotional disturbances and interpersonal problems are a product of history- Reconstructing the past and making repressed memories conscious are not part of the therapy |
| Indication: | <ul style="list-style-type: none">- Possible for patients with heavy ego function disorders |
| Duration/ Frequency: | <ul style="list-style-type: none">- Ca. 25 sessions, 1 session per week- Time limitation is set, when the focus is formulated |

The basic ideas of Strupp and Binder go very well with the musictherapeutical demands because of its interpersonal approach which means that the human relationship is of central importance.

The focus of the sessions is not on the reconstruction of the patient's life story or on making repressed remembrances conscious but on the awareness of the patient's enactments of his neurotic conflicts in the therapeutic relationship. (Thereby memories of the past are being involved and they are being connected to the whole life story.) The demand is "to clarify the manner in which anachronistic beliefs, wishes and fantasies complicate the patient's interpersonal relations in the present"³.

The assumption is that the therapeutic relationship is based on the fact that two people take part in a structured interaction. Both of them perceive this relationship

3. Strupp/Binder 1984:26

from different and dependent perspectives. The behaviour and the attitude reflect these perspectives of which both the patient and the therapist are influenced.

Working on the relationship between the patient and the therapist is the main focus of the therapeutic effort. And exactly this concept of the therapeutic relationship allows us to understand the musictherapeutical activities and expressions and it helps to understand the way in which the therapist takes part – meaning the therapist's actions and reactions.

As all of us know the therapists activity (action and reaction) – which I will describe in detail later on - is a very specific characteristic of music therapy working with improvisation.

After the overview of the sense and understanding of the general psychodynamic approach and the historical development of time limited dynamic psychotherapy we are now coming to the Focal Music Therapy Concept.

Focal Music Therapy

TABLE 5. Focal Music Therapy

Focal Music Therapy main therapeutical components

- **indication and preconditions**
- **goal**
- **time**
- **musictherapeutic stance**
- **transference and countertransference**
- **dynamic focus**
- **defence and resistance**
- **music and experiencing music**
- **musical mechanisms of effectiveness**
- **technique and interventions**
- **a psychodynamic musictherapeutic model of understanding**

The main psychodynamic musictherapeutical components which are also key components in the focal work are: indication, goals, musictherapeutical stance and attitude, transference, countertransference, defense and resistance, technique and interventions, time, experiencing of music and musical mechanisms of effectiveness, and as specific components of this concept the work with a dynamic focus and a psychodynamic musictherapeutical »model of understanding«.

Some of them I am going to describe and especially the importance in focal working.

The presumption of the concept is a 2 to 4 month duration of inpatient or outpatient treatment with an average frequency of 10 to 25 hours of music therapy. Whereas I have developed the concept working with psychiatric patients it does not mean that it can only be applied for those patients.

INDICATION

The indication depends on the willingness and the capability of the patient to work on his emotions and conflicts in the therapeutic relation at least basically. It also depends on the assumption whether a main problem can be defined, whether it should or can be treated with musictherapeutical techniques and whether it is possible within the limitation of time.

AIM

The aim of this focal work is to experience, to understand and to work on early unfinished interactions. Thus the patient is able to develop new and "better" relation qualities and living strategies in general. The personnel aims of the patient which are agreed between the patient and the therapist at the beginning of the therapy have to be linked to the early unfinished interactions.

Transference and countertransference.

The understanding of transference in this concept has to do with the fact that the patient is selectively attentive to a single aspect of the therapist's musical behaviour and personality; that the patient is forced to choose one set of interpretation rather than others. His emotional life and adaptations are unconsciously governed by the particular viewpoint he has adopted and mostly important that he behaves in such a way as to bring out reactions that fit with his viewpoint and expectations.⁴

Countertransference in these terms means (referring to Kernberg) the following: "Through conscious and unconscious modes of relating, the patient evokes in the therapist internal affective reactions that symbolically represent facets of the patient's internal world. The therapist's reactions to this stimulation may directly reflect the patient's conscious and unconscious wishes or other aspects of his or her self-experience, or they may reflect disavowed aspects of the patient's self-representations and object representations."⁵

In this sense countertransference allows us music therapists through musical interactions to take part in the inner life of the patient. To interfere in this sense and to cause changes is influenced by different factors which themselves need special attention.

Defence and resistance

As you may guess right from the beginning it is necessary to take the defence as an intrapsychic phenomenon and resistance as an interpersonal phenomenon into consideration.

The musical interaction is an opportunity to understand and to hear the defence and the emotions behind it through the audible musical shape. Afterwards it is possible to make it understandable for the patient – slowly and softly – again through the musical shape.

Central questions in the musical interaction are: What is the unconscious intention in the musical interaction? What does the patient do to avoid reaching his aim? And how does the patient motivate the therapist to follow him?

But first of all we should ask questions like: what does the patient need to be able to use the musical interaction in a music therapeutical sense. Answering this we have to deal with the musictherapeutical attitude.

4. Strupp/Binder 1984:145

5. Kernberg 1980 in: Strupp/Binder 1984:147

Music therapeutic attitude

Music therapeutic attitude means the musical way of transforming qualities which can be assigned to a therapeutically attitude; qualities which can be described as unspecific mechanisms of effectiveness. I have already discussed this in my publication of 1996⁶ based on CIOMPI – who describes the therapeutic attitude qualities which have a favourable influence on human development in general.

These qualities are:

- quiet and calmness
- simplicity and lack of ambiguity
- dependability and continuity
- trust and directness
- tolerance
- authenticity

In this context »quiet and calmness« is to be understood as short, clear and calm musical motifs based on a calm metrum.

Or in the case of getting faster there has to be an appropriate metric and rhythmical accent like half of the tempo.

»Simplicity and lack of ambiguity« can be realised by using clear and comprehensive rhythm, tonality and melody sequences.

»Reliability and continuity« can only be communicated perceptibly by musical presence so that the therapist is becoming a real partner in a real dialogue as well as in a symbolic dialogue. This can be realised by a stable and "going-with" metrum" (vibrating) or by repeating motifs.

Another possibility is to wait for "the come back" which means hanging on to the original rhythm and tonality. With this aspect I want to emphasise the necessity of not following every single deviation.

6. Storz, D. 1997: 118-120

»Trust and directness« are understandable by musical support, accompaniment and by strengthening. In addition to this it is important that you do not surprise or provoke unreflected or to use "musical tricks". In other words it is a straight foreword musical approach in which the created musical expression of the therapist is understandable.

»Tolerance« means that every possible expression is to be accepted. This means to respond to the musical language of the patient and to follow some deviations resulting also from not being used to play an instrument.

»The authenticity« is to be seen in the context of a symmetric musictherapeutical relationship in which we act as real partners in a nonverbal play. If the authenticity does not exist, all the other qualities are unbelievable and without effect.

These general musictherapeutical principles should create the condition to develop something unique for the patient himself.

Developing more security and an increasing musictherapeutical relationship are preconditions to make the patient interested in his own "relation-experience" and "relation-behaviour" within the musical interaction.

By using the above described principles we create enough space and possibilities for this process.

(Some of these qualities have already been described in Kenneth Bruscia's Book "Improvisational models of music therapy" (1987, Springfield, Illinois, USA: Charles C. Thomas Publisher).

Strupp & Binder also give the therapeutic stance a prominent role and they have formulated 25 principles of the therapeutic stance. What I did was to check if they can be used for the music therapy, completed them and made a list of musictherapeutical attitudes.

To give you an example I'd like to outline some of these principles

- From the very beginning of the musictherapeutical process it is important to explain the possibilities, the sense and the procedure of the common music therapeutical work as well as the handling of the instruments – and this in an every day language.
- It is also important, to explain that the common work and the therapist's support for the patient consist of taking part in his/her inner life through improvisation

and therefore understand his/her musical expression and the kind of relationship he/she initiated.

- Another principle is that the therapist should not interrupt or stop the common improvisation until he/she understands what the patient is trying to communicate. Right from the beginning we have to stimulate the patient's curiosity and interest in him/herself and in improvisational collaborating with the therapist.
- The verbal language and the musical language have to be understandable and should correspond to the every day language.
- One more key issue is not to interpret every improvisation like being omniscient but to describe the musical and dynamical qualities and to complete with questions step by step.
- Interpretations only make sense and are helpful at a later time.

Such principles of a musictherapeutical stance are really helpful to work clearly and understandable with the patient and they are also a basic of musictherapeutical techniques and interventions.

Musictherapeutical techniques and interventions

"Musictherapeutical techniques are being realised in the conscious combination of psychotherapeutical techniques like holding, mirroring, confronting, interpreting a.m. and the specific use of musical elements like metrum, rhythm, timbre, tonality and dynamic."⁷ (Storz, 1999)

The techniques which are used in this concept are mainly: support, containment, exploration of the musical interaction, questions to understand the experienced, incorporation or the use of material from outside the therapeutic relationship (themes, dreams, problems with other persons), confrontation, clarification and interpretation.

To put these techniques into practice we have to use the musictherapeutical forms of intervention which are all kinds of improvisation.

7. Storz, D., 1999: 445

The focus of interest is the free improvisation as a musical interaction between patient and therapist, in which early patterns of relationship are enacted again. Experiencing these patterns is the presumption for the next steps which are: repeating, clarification, confrontation and finally interpretation.

Improvisations which are oriented on formal rules, themes or forms of communication support the structuring on the one hand and the clarification or confrontation on the other hand.

Of great importance is a conscious management of time. Referring to James Mann we divide the therapeutic process into 3 phases:

In the first phase the supporting improvisation is in the centre of attention and in this phase we aim for the development of a dynamic focus.

The second phase is dominated by the experience and the expression of the patient's interpersonal world and by the enactments of his early patterns of relation.

In the phase of separation which is the last phase the central topics are to realise the patient's wishes of the kind of interactions and to work on themes referring to the discharge and the farewell.

The essential point in this concept is the musictherapeutical work with a dynamic focus. This focus serves as our reference point during the whole therapeutic process.

The Dynamic Focus

The dynamic focus has to be worked out to understand the patient with his failed patterns of relation and his ineffective attempts of conflict solving. And also as a decisive help for not losing the goal in the course of the common musictherapeutical improvisational work.

Based on the transference situation in the musical interaction the focus should refer to an interpersonal pattern of relationship which has been biographically important and still creates difficulties in the actual life.

Both the biography and the actual life situation is explored in interviews.

But the situation of transference becomes perceptible and audible much quicker in the musical interaction than it does in therapeutic interviews.

So from the very beginning, the musical interaction has a specific function in providing useful hints about how a patient habitually represents interpersonal relationships. The common improvisation shows how the patient creates the relationship and it also shows what the basic expectations of the patient are.

When we formulate the focus the central impressions and the information we already have are being connected and interpreted. We have to name the patient's strategies behind his current patterns of behaviour – for which he certainly had a good reason in the past but became destructive to a certain extent in the present.

The formulated focus should be about 2 to 3 sentences.

A CLINICAL EXAMPLE:: MS. D.

A 24 year old woman came to the department with the diagnosis: Borderline psychosis with heavy depression and eating disorder.

She talked about an emptiness, uncertainty, being without orientation and a bodily misperception of dissolving. She also mentioned difficulties with limits and boundaries and a tendency to follow other people and to have to do what others do.

She had a very negative self-perception which resulted in anxiety and which also could lead to the feeling of dissolving and massive self-devaluation.

Ms. D. grew up on a farm in a small village in Austria. Her father was very strict and did not talk much whereas her mother was overtaxed from work. Ms. D herself had a particular function for her mother, namely meaning not being alone. Her mother was overprotective and the patient was quite restricted in her activities. She talked about her role as an outsider and already in the kindergarden she had problems to get into contact with others. Even with her 5 older brothers it was not possible to establish a (closer) relationship because they spent their childhood at a boarding school.

At the age of 9 to 13 she had a "forbidden sexual relationship" – that's how she called it – with a guy two years older than she. It was not really possible for her to talk about this relationship. The only thing she told was that she ended this relationship because the guy talked in an insulting way about her privately and in the public over and over again. When she was 14 she went to high school which was a boarding school that meant she had to leave the parental home. Since that time she has

felt without any orientation but nevertheless she could finish the school with a positive high school diploma.

Afterwards she went to Vienna, lived in a student house and started at university – the nutritional science course. Very soon she fell into a miserable and stressed mood with anxiety, sleeplessness and the feeling of making everything wrong.

The following symptoms were eating difficulties, heavy affective outbursts, weeping spasms, crying fits and at least psychotic symptoms like ideas of reference and delusional ideas. So she stopped her studies and went back to her parents, but her state deteriorated more and more, hence her parents took her to the next hospital.

At the rehabilitation department her goals were to develop a better feeling of reality, to find more orientation, to work on her self-esteem and on her problem of identity and to improve her interpersonal abilities.

The team on the ward suggested that central topics for her were how to accept herself and how to accept the need to be understood and to be loved as well as the need to reconcile with the aggressive part of her personality.

In our first musictherapeutical session she was very shy and it was hard to get into contact with her. She talked very little and answered my questions only.

Again and again she tried to catch my eyes and it seemed as if she watched every single movement in my face. She appeared to be frightened but also sceptical and curious.

We talked about the character, sense and procedure of the music therapy, the sense and possibilities of a common music therapeutical work. Finally we had agreed on two sessions per week during her stay at the department.

The first sessions were to get familiar with the instruments and to explore them and to get an idea of the different possibilities of playing them. After this we could start with our musical interactions.

Right from the beginning she could use the free improvisation in an amazing way. Not only could she find musical impressions for her inner life in a very differentiated way but also was she interested in my part and in our common musical interactions.

My feelings and reactions which came up more and more were:

- The feeling of being controlled
- The feeling of being tested, whether I am doing and understanding well enough
- The feeling of controlling myself so that I do not fail to hear something and that I don't say a wrong word or play "wrong"
- The feeling of not being able to "give" enough to her meaning that she never gets enough

Her general expectations referring to others and to my reactions:

- She was sure that others would reject her – me too. These fears were nourished by her memories of heavy mocking and constantly teasing during her kindergarten and school time.
- She seemed to be afraid of being disappointed by me.

Her reaction in the musical interactions:

- She was looking for love and care
- She perceived relation qualities very quickly
- She was mostly dissatisfied with her reactions (because she could not answer good enough)
- When she "failed" in her attempts answering my musical acting she derogated herself and withdrew from the relation.
- Therefore after lots of intensive and exciting improvisations she was in a sad and reproachful mood

These components made me to formulate the focus, which served as our common basic motif. It is important that the formulated focus addresses her personally and was:

»In our improvisations it seems as if you try hard to show me what you need from me. And at the same time it seems as if you fear that I will not be able to perceive and to understand your needs. I also have the impression as if you are sure that I am not able to reply well enough. Your presumptions put you under the same strain as it was in your childhood. Your reaction is to withdraw from our relationship and to go back to your well know feelings of being left alone and of being full of self-doubts as you did in former times.«

Initially Ms. D. was quite disturbed about this interpretation because she supposed criticism and rejection behind this idea. But when I emphasized the logic of her atti-

tude and her behaviour and the way it was connected to her biography she could – after a while – agree with interest and relief to this interpretation.

This formulated focus was our guideline for the whole work.

We created quite diverse improvisations and she was able to express her mental state – her troubles and difficulties as well as her pleasant feelings.

Again and again we had to cope with the difficulties as formulated in the focus: her expectations and the withdrawing from the relationship in order to avoid disappointments. By the time she was able to recognize these processes more and more consciously. Whereas at the beginning she was very negative about herself and later on she could gradually reconcile with these parts of her personality and at the end of our work she could even be partly humorous about herself.

Summarizing the musictherapeutical work with a dynamic focus means that the whole musictherapeutical process is dominated by the components of the relationship in the musical interaction.

The musical interaction represents something like an "acting-relation space" which allows us to try out different patterns of relation so that they can be experienced and become clear. This offers the possibility to constantly link everything that happens in the improvisation to the formulated focus.

For the patient the advantage of a dynamic focus is that the musictherapeutical work becomes clear and comprehensible. Thus it is more likely that the patient develops a growing interest in himself and that he sustains this interest in himself. Time limitation does not necessarily mean not to work psychodynamically but to use an appropriate concept. In this case it is the Focal Music Therapy Concept (FMT) which can be helpful for both the patient and the music therapist.

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CHAPTER 56

*„Low technology“; necessary aids in
music therapy practice with children
and adolescents suffering from*

*multiple serious
impairments*

Thoms, Karen

Editors note: Check for the html version with all video and audio files on MusicTherapyToday.com (November 2005)

Perhaps I should have been honest and should have chosen a different title for my presentation, something like



“Not the chimes again!” – Looking for alternatives to chimes in music therapy practice with patients suffering from multiple serious impairments

This title is a first indication of why I began to look for ways to design and construct aids and devices for music therapy practice. Five years ago I would not have believed this could become a central issue in my work – but five years ago I did not know the place where I work today, the “Lebensarche Königsborn”, nor did I know the residents of this institution. The aids and devices I shall present here are a result of my work there, tested and tried out many times and changed and refined accordingly. The inhabitants of the Lebensarche gave and give clear and honest indications whether and in which context these aids are suitable or not.

This is why I shall begin with a short presentation of this institution and its inhabitants, and then go on to describe my work as a music therapist and the challenges I faced from the start. Then I shall present a number of aids and devices constructed for music making, and show videos from therapy sessions to illustrate ways to use such devices.

1. Lebensarche Königsborn

Lebensarche Königsborn is part of a larger institution called Lebenszentrum (or life centre) Königsborn – a centre for patients with neurological diseases or impairments. About five years ago this centre was reorganized, and the clinic for pediatric neurology with 50 beds was turned into a residential home. This type of care corresponds to the specific needs of pediatric and adolescent patients; their serious impairments in daily life require permanent support by therapists, teaching and nursing staff. For a variety of reasons, this care cannot be provided at home; therefore, children and adolescents between 0 and 24 years from Northrhine-Westfalia live in this centre for many years. Their serious multiple impairments are caused in most cases by traumatic brain injuries, inflammatory brain disease or neuromuscular disease.

After reconstruction, the Lebensarche now gives room to 6 groups with 8 inhabitants each, with family-type structures and supported by an interdisciplinary team of carers. 15 therapists provide their services according to the individual needs of the inhabitants. Children and adolescents at school age attend a special education school.

2. Music therapy at the Lebensarche

I came to this institution five years ago and have been working as a full-time therapist for the last three years. I see all 50 inhabitants in music therapy in the form of alternating therapy blocks, mainly in single sessions. The objectives of my efforts are varied and comprise relaxation, perception or stimulation of contact and interaction. Although the children and adolescents have serious impairments of motoricity and also cognition, it has always been my intention to involve them in an active way. For example by reflecting and imitating their respiration and movements in music. In addition, I am always looking for ways to let them actively participate in music-making with instruments.

I have a wide range of instruments in my therapy room: drums, rattles, castanets, and triangles. Along the wall, there are a slit drum (Big Bom), cymbals, metallophone, pipedrum, sound bowl and chimes. As many inhabitants of the Lebensarche suffer from cerebral paresis, or marked spasticity and athetosis in movement patterns, it is difficult to involve them in active music-making. From the very beginning, only the chimes turned out to be suitable to make even smallest movements audible, and to integrate uncoordinated movements.

Consequently we are challenged to improve the conditions in which patients with serious multiple impairments can find access to, and use appropriate instruments.



The traditional instruments in a therapy setting may in fact be played without previous experience. Nevertheless, there are some basic preconditions for music-making with instruments:

- First of all, we need **movement** – no sound, of instruments or otherwise, can be produced without movement, e.g. the movement of hands and arms, or the movement resulting in inhaling and exhaling.
- For the drums or castanets we need in addition a **directed movement**, a movement towards the instrument; this may of course be facilitated with a flexible position of the instruments but is required nevertheless.



- With the metallophone or cymbals, there is an additional requirement: **a stick has to be gripped and held** firmly in order to be taken to the instrument.



- Many times I saw a patient grip a stick and guide it towards the instrument, but if the movement was very slow then there was no satisfactory sound. It is a deeply frustrating experience to see somebody sit in front of the cymbals, mak-

ing a tremendous effort to take the stick to the instrument slowly and then to softly drop it to the cymbals without a sound ... another precondition is therefore a **minimum of speed in the movement**.

- In the case of stringed instruments, e.g. the lyre, sound is produced by plucking the strings, which requires **mobility in individual fingers**.

We tend to underestimate these requirements because we do not have to think about them. But if you work in an institution such as the Lebensarche then you are confronted with such problems. The inhabitants challenge us to take a closer look at the things we normally do not think about, and at the basic requirements in particular.

3. Aids and constructions for music-making

3.1. TILTING TABLES WITH ADJUSTABLE HEIGHT



In music therapy with seriously impaired patients, the mere positioning of instruments is very important; instruments must be adjusted as exactly as possible to their needs. They require tables and fixtures that can be adjusted flexibly as to height and angles.

Wooden boards fastened to metalophone stands with screws have turned out to be useful. Such tables permit e.g. to set instruments up on end, or castanets may be fixed hanging downwards, so that they can be moved with feet. We shall see more of such table constructions later on.

3.2. FUNCTIONAL GLOVE / SANDAL



As mentioned above it is difficult or even impossible for many inhabitants of the Lebensarche to get a firm grip on an object or to hold on to it. Some of them are able to grip a stick, but their play on an instrument is often interrupted by an uncontrolled opening of the hand: the stick falls down, and the joint play stops. This is why we designed a glove with Velcro fastening; another Velcro fastener at the handle of the stick ensures that the stick is held even if the hand opens. I think it is important that the natural grip of the hand is involved and that the Velcro fastener is only a safeguard.

Clients have to be observed closely in music therapy; when they let go of the stick, this may also indicate that they just wish to stop playing. We must be aware of this possibility!



Normally we use hands and arms to play drums, cymbals or glockenspiel; for some inhabitants of the Lebensarche it is easier to use their feet and legs. Therefore we had to design devices to fasten sticks to the feet, and this is the result: a sandal with Velcro fastening adjustable to the size of the foot, with quivers or loops at the sides

to hold sticks or instruments. This sandal for sticks permits music-making with feet or legs.

3.3. HEAD FIXTURE WITH STICK



In several cases I also use a kind of fixture to the head – a device that makes use of head movements. This is not my own invention – it was designed for work at the computer keyboard, and I used the idea for music therapy. For Nermin e.g. I fastened the plectrum of a guitar to a short wooden stick and screwed this into the head fixture. Therefore she is able to play the lyre with a head movement.

4. SCHNUKOS®

The next device I want to show you are Schnukos® – this is an abbreviation of the German word “Schnurkonstruktion” or cord construction. The point of these cord constructions is that the movement is transferred to the instrument via cords. Many patients are able to move their arms, legs or head, but a controlled movement towards the instrument is almost impossible because of athetotic motor disorders, i.e. uncoordinated and overshooting movements. The Schnukos® allow to transfer motor impulses of all types to the instruments in such a way that movements become audible and instrumental play becomes possible. The simultaneous coupling with a sound-producing instrument may promote and support a patient’s perception of his own activity and his sense of self. The Schnukos® allow to hear, experience, perceive and perhaps to enjoy movement.



4.1. SCHNUKU (SCHNUR-KUGEL-KONSTRUKTION OR CORD-SPHERE CONSTRUCTION)

My very first Schnuku consisted in nothing but a long cord, a wooden sphere and a stand; one end of the cord is fastened to the stand. Drum, cymbals or glockenspiel are positioned accordingly.



4.2. KUPIPE (KUGEL-PIPEDRUM-KONSTRUKTION OR SPHERE-PIPEDRUM-CONSTRUCTION)

Subsequently I designed the Kupipe – a construction where a wooden sphere runs along the edge of the up-ended pipedrum. The tilted table permits a vertical position of the instrument. An important discovery for me is a deflector role: it serves to take up and integrate the movements even better.



4.3. TRIANGLE TREE

The triangle tree is based on a similar idea. Several triangles are hung into a wooden frame. A metal sphere or iron nuts are directed to the triangle via a deflector role and produce sounds.

4.4. SEESAW-TABLE



The seesaw table is another alternative. A wooden box is hung up in a freely movable position and may be tilted forward with a cord; a weight at the back wall causes it to tilt back. In this wooden box we may fasten e.g. an oceandrum. But more frequently I use a wooden sphere on a track or rail that causes claves to sound at both ends.

An important characteristic of these Schnukos ® is that not only *one* direction of movement produces a sound of the instrument – as is normal with drums, metallophone or other percussion instruments – but that the movement in the opposite direction becomes audible as well: movement up *and* down, back *and* forth.

4.5. LEVER STICK



In addition to the normal Schnukos®, other cord constructions have been designed which make use of the lever. As mentioned above, some of my clients are so slow in their movements that they produce almost no sound at all on an instrument. This is why I designed the lever stick. The principle is very simple: a hole is drilled into a stick and the stick is hung up so as to move freely. Even a slight pull at the short end of the stick causes the tip to move a far longer distance, and more rapidly, in dependence on the ratio between short and long part of the stick.

4.6. KUPIPE WITH LEVER STICK



The idea of the lever may be combined with other cord constructions as well. The last Schnuko® I want to present to you is a pipedrum with a lever stick. The principle is the same as before; but this time I fastened a cord with a wooden sphere at the end of the stick. In the example presented here it is enough to pull 4 cm in order to guide the sphere over all pipes of the pipedrum.

5. Types of fixtures or fastenings

What about the fixtures or fastenings to play the schnukos?



- The therapeutic glove, the stick sandal or the head fixture may be employed to use movements of arm, leg or head in music-making with Schnukos.



- In addition, we may use simple wooden or plastic handles or rings.



- This hand grip was made specifically for the Schnukos. It uses the normal gripping movement; Velcro fasteners over the back of the hand and around the wrist make continuous play possible.



I discovered a very cheap alternative to the stick sandal in a toy shop: Bobbycar shoe protectors! They have a rubber coating that is glued to the fronts; I replaced it with a Velcro fastener, glued another Velcro fastener to a wooden cube and added a ring screw, and had produced a wonderful device for music-making! Two of these for just 8 Euro!

Moreover Schnukos ® have some other advantages:



1. Hygiene is easier to ensure with patients who suffer from infectious diseases. Wooden handles are inexpensive and may be provided for each patient.
2. For patients with impaired vision, the tactile impulse may support and maintain contact with the instrument.
3. Instruments may be positioned in more variations and need not be placed directly near or in front of the face or head.

6. Plectrum stick

Stringed instruments may be easily used with the help of plectrum sticks. A simple guitar plectrum is fastened to a wooden stick with a saw cut.

Depending on each patient's condition and abilities, it may be fastened to a T-stick, or to a longer wooden stick that may be fastened in the foot fixture.



7. Conclusion

In conclusion I would like to come back to the preconditions for making music on a variety of instruments, and to describe how it became possible to ensure a satisfactory and joyful play on instruments even without these preconditions.

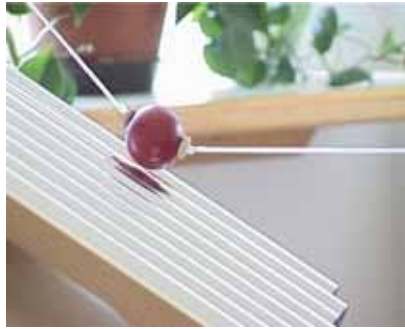
- One condition is the ability to close a fist in order to get and keep a firm grip on a stick. The therapeutic glove, the stick sandal or the head fixture make it possible to play an instrument with hands, feet or head. Velcro fasteners permit something like continuous play.
- Another precondition is the directed movement towards the instrument. Cord-constructions help to translate all kinds of movement patterns into music-making on instruments. The cord serves as a “funnel” between player and instrument.
- Even the requirement of a minimum speed may be evaded:
- The lever stick, either alone or in combination with other devices, may considerably accelerate or enhance movements.
- A plectrum stick may facilitate music-making on the lyre or other stringed instruments even for patients who are unable to make plucking finger movements.

The search for alternatives produced first results; we designed aids that helped to involve almost any type of movement into the production of sound – and this is what we see in the music with chimes, irrespective of the body part that moves, and irrespective of the speed or direction of the movement.

In my therapy sessions, I am always impressed by the concentration, the persistence and also the delight and pride with which children and adolescents react to the new possibilities to make music; this shows me that we have chosen the right direction, and I am looking forward to seeing where this path will lead us.

I want to conclude my remarks with a quotation by G. Dörr that has influenced my work again and again; I hope it encourages all of us to go on looking for new ways and developing new ideas:

“Serious physical handicap seems to be an obstacle; in reality it challenges our imagination. If the way we treat each other then this is integration, and integration in this sense will eventually become a path on which both involved parties move along and take steps towards each other. No, this is not possible.”



(G. Dörr)^a

a. DÖRR: Vorwort. In: Fröhlich: Kommunikation und Sprache körperbehinderter Kinder. (1989, S.8)

CHAPTER 57

Home alone: The use of familiar pre-composed songs in individual homes of the elderly

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Introduction

What I wish to present to you today is how music therapy in the individual homes of the elderly can assist in the re-engagement of positive feelings, and thus re-engaging them with coping skills. Music, and in particular familiar pre-composed songs, evokes strong and positive memories. This reminds them of positive emotion and allows them to re-engage with a previous time when they could cope. This allied health profession is viewed by medical professionals in the community as offering a creative medium for expression which fills a gap in health care in Australia.

An increasing number of elderly people with high-level needs are remaining in their homes for a longer period of time and for a variety of reasons. This trend in Australian health care has caused a shift in service provision and requires a range of support services. With longer waiting lists for nursing homes, government and private organisations have implemented and increased home services in Australia. These services include home help in cleaning, food preparation and shopping. The increased number of services in the home often delays the immediate need and decision to move to a nursing home or hostel, until it is absolutely necessary. In the mean time the many issues of ageing accumulate. Despite the services provided in the home, these people often face similar challenges of ageing to those of nursing home residents including grief, loss, depression, increasing dementia, isolation and coping difficulties.

Music therapy, and in particular the use of familiar pre-composed songs to facilitate reminiscence, has been widely used in the care for the elderly. It has traditionally addressed physical, emotional and social needs with this population in nursing homes. Through case vignettes, this paper will demonstrate the effective use of familiar pre-composed songs in the homes to remind elderly people of re-engage with feelings of happiness and thus assist them to cope in their homes independently for as long as possible.

Familiar Pre-composed songs with the elderly

We understand music therapy to have many positive effects for the elderly population. Sato Ashida reported of music therapy research in this population to increase motivation, increase self-expression and communication, evoke memories, provide a sense of accomplishment and address short term memory loss. A well used music therapy technique known to us with this population is the effective implementation of familiar pre-composed songs. In Australia, this is the most common experience of music is through song, and this is subsequently a very age appropriate format with the elderly population. They are often songs people grew up with, sang around the piano and danced to. The use of this type of music provides "...structured reality, order and predictability..." whilst facilitating reminiscence and discussion associated with emotions such as loss, grief and isolation. (Clair, 1996) They hold associations of people places and events. Suzanne Hanser (1990) discusses how these associations with familiar music often evoke pleasant memories, providing a stimulus in music therapy sessions for positive life review. This music therapy technique can be effectively used as the ageing process progresses physically or cognitively. With increased dementia the retrieval of verbal language becomes

increasingly difficult, and it is the use of familiar music associated with positive experiences and memories that is most likely to evoke a response (Clair, 1996).

The implementation of familiar pre-composed songs in a music therapy session with the elderly often has a focus on reminiscence and life review. However it also provides a perceived “safe” environment for people to share their memories (Ashida, 2000) and meaningful experiences. The music can instil a sense of reassurance and companionship and this use of music helps to evoke meaningful interactions between the therapist and participants.

Music therapy in the home

According to the Australian Bureau of Statistics in 2001, between 1981 and 2001, the population of people over the age of 65 who lived in some form of aged accommodation with supports, increased by 500%. It is anticipated that our ageing population will only continue to increase. The consequences of ageing include dementia, depression, isolation and disempowerment. These can cause impairment in activities of daily living (Monini et al., 1998), psychological distress in the elderly and their carers (Brodaty & Luscombe, 1998), and higher rates of institutionalisation (Folstein, 1994). It may also cause people’s coping skills to be disabled. With the ageing population of Australia increasing, and nursing home beds becoming harder to obtain, general home based programs and supports to care for the elderly are beginning to become an important part of our community.

Music therapy in the home is relatively new for our profession. Home based palliative care services are well established in Australia and continuing to increase in size and number. Whilst traditionally addressing issues of ageing in nursing homes and hostels, the implementation of music therapy in the homes of the elderly has many benefits. Music therapy sessions with familiar pre-composed songs emphasize meaningful experiences, allowing participants to focus and re-engage with positive feelings of happiness and uplifted spirits. Music therapy becomes a point in their weekly life, enabling them to feel empowered as they look forward to their next session. This positive experience created through regular music therapy sessions in the home with familiar music can assist the elderly to remember a time in their life when they were able to cope. It therefore impacts on the delay for the need of admission to a nursing home.

Calvary Health Care Bethlehem

In 1999, Calvary Health Care Bethlehem and the Royal District Nursing Service were successful in obtaining government funding to implement a home-based music therapy program. This program is provided for the frail aged with psychosocial needs who live in their own home. These two health facilities have worked closely together to provide better care for the elderly in the community.

Calvary Health Care Bethlehem is a public hospital in Melbourne, Australia, owned and operated by the Sisters of the Little Company of Mary. The hospital cares for people suffering with progressive neurological disorders, or people diagnosed with cancer or other illnesses who are in the last months of their lives. The music therapy department of Calvary Health Care Bethlehem largest of its kind in Australia, with 7 music therapists providing services to in-patient, home-based and outreach services including the program provided to the Royal District Nursing Service.

Royal District Nursing Service

The Royal District Nursing Service aims to provide their clients with effective and efficient quality home health care programs 24 hours a day. The music therapy program is part of the allied health team who works in conjunction with nursing to provide a holistic approach of care within the home.

Home-based music therapy program

The Royal District Nursing Service has 20 centres across the Melbourne metropolitan area, and the music therapy program is run 2 days a week over 2 centres. Clients of the Royal District Nursing Service are referred to music therapy for a variety of reasons, predominantly to assist in their general care management and well-being. This program provides music as an age-appropriate format to address issues which are not able to be addressed by nursing staff in the time allocated or with the skills required. The reasons for referral to the music therapy program include social isolation, dementia, anxiety, pain management, and emotional or spiritual support. All of these reasons for referral impact on an individual's independent living and coping skills.

The following case vignettes give examples of the effective implementation of familiar pre-composed songs in music therapy sessions. All names have been changed for issues of confidentiality and permission granted for use of material.

CASE VIGNETTE 1

Jim, is an 87 year old man, who presented with short term memory loss, depression and insomnia. He lived alone in a one bedroom unit, and was being visited by the district nurse daily for management of medications.

It was observed by the district nurse that Jim's general health and independence was deteriorating. Jim would often stay in bed all day without getting dressed, his home was becoming increasingly unkempt, and he reported increasing insomnia with intrusive nightmares, centred around the death of his first wife in 1955. He was referred to music therapy by his primary nurse to address increased confusion, depression, short term memory loss and grief issues.

On the initial music therapy visit, Jim presented with a very low spirits. He was very open about the difficulties he was experiencing and also expressed feelings of guilt and that he could not see the point in life any more. Due to the complexity of his feelings of guilt I will not expand on this reasons relating to this. He was willing to accept music therapy, however made it clear to the therapist that he did not feel it would benefit him. Over a period of months the music therapist played live familiar music at his bedside during sessions to stimulate discussion and reminiscence, whilst addressing the death of his first wife. The music therapist played familiar pre-composed songs such as "Heart of My Heart" and "The Street where you Live" from 'My Fair lady'. The playing of this familiar music and manipulation of tempo by the therapist stimulated increased conversation by Jim. The song "Wouldn't it be Lovely" from 'My Fair Lady' had particular meaning to him.

All I want is a room somewhere

Far away from the cold night air

With one enormous chair – oh wouldn't it be lovely

Lots of chocolate for me to eat

Lots of coal, makin' lots of heat

Warm face, warm hands warm feet – oh wouldn't it be lovely

Oh, so lovely sittin' abso-bloomin'-lutely still
I would never budge till spring, crept over the window sill

Someone's head restin' on my knee.

Warm and tender as he can be

Who takes good care of me

Oh, wouldn't it be lovely

Lovely, Lovely

Lovely, Lovely

The music therapist used the words of this song to stimulate discussion about what he had hoped for his marriage, before his wife died. They were pleasant memories, and pleasant dreams, and enabled Jim to comfortably express emotion such as laughter and tears.

The majority of sessions centred around the death of his first wife and associated guilt, and was supported by the music therapist with appropriate familiar pre-composed songs such as this one. Verbal prompting was occasionally used by the music therapist due to Jim's memory loss. With the music therapist allowing the song stimulated discussion to flow freely Jim, was also able to relive pleasant memories and enjoyable activities such as music and gardening. Gradually Jim was able to recall more songs during music therapy sessions, indicating uplifted spirits and creation of increased stability in his life. He began to request music therapy sessions in his living room, where the photos of his wife and family were kept, and often referred to them following songs such as "One Enchanted Evening", recalling his days as an usher at a movie theatre and his days of dancing.

Jim now receives music therapy fortnightly. He often greets the music therapist in his garden, where he works hard in on a daily basis. He receives daily nursing visits for medication, and home help once a week. He is becoming frailer and his dementia is becoming more evident, however he lives relatively independently with support and does not wish to leave his home and his garden. His nightmares now occur only occasionally.

It was believed by the primary nurse, that music therapy was a strong contributor to Jim's uplifted spirits, motivation and maintenance of independence as it was the only change to his general care. Jim continues to address issues of grief and guilt

during music therapy sessions. The music therapist plays familiar pre-composed songs which are known to elicit a verbal or emotional response by Jim, remind him of his wife, and create an appropriate environment for him to express his emotions comfortably. This implementation of familiar pre-composed music in the home, is a positive experience for Jim. It has enabled him to establish better coping mechanisms through the stability and predictability the songs create. Jim speaks very highly of music therapy to his primary nurse and the music therapist, and looks forward to his fortnightly sessions. His primary nurse no longer raises the issue of placement into a nursing home.

While Jim's case was an example of the implementation of familiar pre-composed songs for an elderly person who lives alone, the following case vignette illustrates the same technique with a carer to assist in coping skills and effective care management in the home.

CASE VIGNETTE 2

Mathew was a 75 year old man presenting with multi-infarct dementia. He lived at home with his wife Mary in their second marriage. Both of them had experienced multiple challenges in their lives, including the loss of children and alcoholism. Before the deterioration of his condition, they made the decision for Mathew to be cared for at home. This was something Mary felt very strongly about, and she was determined to care for her husband in the best way possible. As a consequence of her determination regarding this, her anxiety levels and criticism towards nursing staff increased, and Mathew's confusion escalated during these tense periods. Nursing staff found this difficult to manage and therefore had increased difficulty in providing adequate care for him to remain at home. The nursing staff's home assessment revealed both Mathew and Mary had extremely high care needs including hygiene and management and appropriate care techniques. They also had psychosocial needs such as unresolved grief, expression of emotion and coping difficulties. These needs were not able to be addressed by nursing staff, predominantly as their visiting time was limited and there were many issues to address. Nursing staff felt music therapy may assist Mathew and Mary address emotions they were currently experiencing and develop coping strategies in Mathew's management of care. Mathew was referred to music therapy for memory loss, disorientation and confusion, agitation, social isolation and difficulty expressing emotion. Nursing staff intended to support Mary in caring for Mathew at home and resist the need for admission to a nursing home as per her wishes.

During initial visits, Mathew was usually in his wheelchair and was able to respond to verbal and musical prompts. This communication included the music therapist singing his favourite songs, such as "Amazing Grace" and "Look for the Silver Lin-

ing”, with Mathew maintaining eye contact and singing. Through songs familiar to Mathew, the music therapist encouraged him to sing and the sessions subsequently offered a significant increase in cognitive stimulation. This stimulation was needed as he was dependent on Mary for his full care, and their relationship had therefore changed dramatically. In addition, Mary’s anxiety was often noted, exacerbating Mathew’s confusion. These sessions became important to reduce tension and anxiety whilst creating a focal point aside from Mathew’s care that they both enjoyed and responded to positively. Mary was educated by the music therapist in the appropriate use of recorded familiar music between music therapy visits. This use of music during the quiet times of the day, and when Mary was feeling particularly stressed, was important in Mathew’s holistic care.

Over the period of nearly 3 years that Mathew received music therapy, his condition deteriorated and he became largely confined to his bed. Periods of extreme confusion and anxiety had increased with little verbal communication. Music therapy sessions became increasingly important for Mathew and Mary by creating an intimate environment and as a time to share their relationship as husband and wife, rather than carer and patient. During these sessions Mary would request songs they enjoyed together and whilst they were played by the music therapist, she was able to communicate with Mathew and reminisce. There were a number of songs that were regularly requested. “The Way we Were”, “Danny Boy” and many of the songs of Dean Martin were requested. “That Lovely Weekend” was one of the songs regularly requested.

I haven’t said thanks for that lovely weekend,
Those two days of heaven you helped me to spend
The thrill of the kiss when you stepped off the train
The smile in your eyes like the sun after rain

To mark the occasion we went out to dine,
Remember the laughter the music the wine
That drive in the taxi when midnight had flown
Then breakfast next morning just we two alone

You had to go, the time was so short, we both had so much to say
Your kit to be packed, the train to be caught

Sorry I cried but I just felt that was

And now you have gone dear this letter I pen

My heart travels with you till we meet again

Keep smiling my darling and someday we'll spend

A lifetime as sweet as that lovely weekend

This song reminded Mary of when Mathew sang to her on their honeymoon. The music therapist often manipulated this song in tempo to create an appropriate environment which supported their emotions and allowed them space for expression. Listening to this song with Mathew, allowed Mary to express her emotions appropriately in their own home.

Familiar pre-composed songs were important in this phase of music therapy. With the music therapist playing familiar songs an environment they perceived as emotionally stable was created and thus supported their issues of grief and loss. The music therapy sessions enhanced open discussion regarding the ageing process, re-engaging them in positive emotions of shared experiences such as the times they enjoyed dancing. This re-engagement and emotional support through music therapy sessions with familiar pre-composed songs filled the gap in the health care provided and assisted in re-establishing coping mechanisms. Mary's improved coping skills prevented the need for Mathew to be admitted to a nursing home.

Following Mathew's death, the music therapist compiled a tape of recorded music for Mary. It included the music therapist singing some of their favourite songs. This was important to Mary as she often commented that the experience was always different when the music therapist sang the songs rather than listening to them on a tape. This familiar music on tape, assisted Mary in the grieving process by allowing her to remember the enjoyable experience that music therapy provided in Mathew's final years.

Conclusion

These case vignettes demonstrate the effective use of familiar pre-composed music in homes of the elderly to address issues of ageing and assist in maintaining independence and coping skills. As the population in Australia continues to age, nursing

home beds are becoming fewer, and more people will remain in their homes for as long as possible. The accumulated consequences of ageing need to be supported and addressed for these people in their own home with a shift in service provision. The strong positive experience of music therapy and the memories it evokes, allows re-engagement with happy emotion and a time when people were able to cope. The implementation of this music therapy program, has made this unique therapeutic medium more accessible to our elderly population living in the community.

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CHAPTER 58

From child care institution to foster family- supporting interaction by means of music therapy

Tuomi, Kirsi

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1. Introduction

In this presentation I will introduce you a model of music therapy developed in Nikinharju kuntayhtymä, where I work. The purpose of this model is to help the child to adapt to a foster family after living in a child care institution. Participants were foster and adopt families. The model was developed because of practical viewpoints. In the child care institution the nurses felt their work didn't have continuity after child had moved to a new family. On the other hand the new families often felt they needed support when the placing process was topical. Music therapy seemed to be a good tool at this point. I knew these children from music therapy groups held in the child care institution, sometimes even from a single music therapy process. I was also interested in this kind of work with families.

In addition to the theories of Donald Winnicott and Daniel Stern the paradigm of the model is the attachment theory. British psychiatrist John Bowlby thought that the attachment theory he had created was some variation of psychoanalysis. Attachment theory is partly based on the observations made of how a mother takes care of the security of her young ones in nature. Animal babies become attached to their mother and try to be close to her. (Kalland et al. 1999.) A human child has the same kind of behavioral system the purpose of which is to keep the distance to the care giver as short as possible. (Sinkkonen et al. 2001; Goldberg et al. 2000/1995; Goldberg 2000; Bowlby 1997.)

The nature of child's attachment varies and a child can become attached either securely or insecurely (Kalland et al. 1999). A securely attached child has not needed to be afraid much and he/she can flexibly change his/her behavior along the circumstances. The more difficult and traumatic environment has been and the more insecure the attachment has been the harder a child holds on the working models he/she has adopted. From the viewpoint of treatment this is a challenge. Sometimes it can take years before a child has the courage to try some other way of being in interaction. (Sinkkonen 2001.)

Either ways the attachment is very often the big issue when it comes to foster care. These children may have been maltreated both emotionally and physically. They have experienced losses in many levels and have poor trust in people. The attachment models they have adopted are often, almost always, very insecure and one purpose of the therapy with these children is to create a relationship where the attachment can be secure. This is also the main target of the model I am today presenting to you.

2. Introction of the model

Experiments of this music therapy model were started in year 2002 and till spring 2003 there had been seven processes altogether. Four of these children moved to a foster family, one to a so called professional foster home and two were adopted. At the time of moving to the new family these children were of the age of one month to eight years. The meetings were arranged with large variety depending on the needs, motivation and possibilities of these families. There were two to thirteen meetings which mainly included meetings with the child and his/her primary caregiver, but also meetings with the whole family and/or part of the family were arranged.

The target of this model is to support both the child and the family at the point of re-placing. On the other hand the purpose is to transfer the knowledge from the institution to the new parents. Music therapy can provide actual implements. With the help of these tools the family can deal with difficult issues such as being rejected, different feelings and changed roles. The interaction between the family members is supported by functional means with the help of music and other arts. The meetings have included singing, playing with instruments and toys, music listening, working with pictures, drama, moving and dancing. The discussions have also been meaningful though then it has been important to pay attention to the age of different family members.

Some kind of path has been developed of this model. As I told you, I am familiar with these children already from the institution. I have been working with all children under school age at least in a group therapy but I have also met some children in a single music therapy. The aim of social care is to find a family for these children, either a foster or adopt family and children are placed in the institution for that time. Sometimes this period can take few months, sometimes even years. My job is mainly to assess and support these kids who have been through a lot.

When the family is found there will be general discussions about the possibility to have music therapy at the stage when the child and family is getting to know each other and after the actual moving has taken place. If the family is interested there will be a meeting in which the child, the family and the music therapist are taking part. It is to be hoped that the nurse and social worker from the foster care institution could also take part in this meeting. The working process and its goals will be discussed likewise the length of the process. Also an agreement is made. Luckily this plan can be reviewed during the process, in other words, if needed there can be less or more meetings than planned or the meetings can be aimed more, for example, at the whole family. The video filming is used as a tool and the tapes will be given to the family after the process is over. In addition, the family will get the lyrics of used songs. After the process is ended the therapist will make a written conclusion which the family is allowed to comment. With the permission of the family this conclusion will be given to the paying part. Also some kind of reflection of the process is wished from the family so that this music therapy model can be developed further.

3. The case of Thomas

3.1 BACKGROUND

Thomas was born in December 2001 and he was the fourth child of his mother. During the pregnancy the mother had used many different kind of narcotics. However, there was nothing abnormal in the delivery and the boy was of normal size. During the delivery the mother was influenced by drugs, amphetamine, and left the hospital three days after the delivery. Thomas remained at the hospital because of his need to have special attention. Despite exhortations of the hospital the mother didn't visit the hospital and Thomas after leaving. The father of Thomas had also an addiction to drugs. With the help of urgent custody, the nursery of Thomas was protected and social care got some extra time to find out what was going on.

Thomas had no clear withdrawal symptoms and so he moved to a child care institution at the age of two weeks. His siblings were also living at this institution. At the age of two months Thomas, however, was moved to Northern part of Finland where his parents had rehabilitation. Thomas got very sick and had meningitis. (meningitis) He was near to death, his skin was gangrened, it abscessed, was teared and went black and blue. Thomas had to stay in the hospital almost two months after which he returned to the child care institution. At that time the motor development had been left behind and Thomas was described as a restless little boy.

From the viewpoint of attachment theory the first six months of Thomas had been nothing but secure. There had been no primary caregiver to whom Thomas could have been attached and the basic security must have been shaken. This was realized in the child care institution and single music therapy was started.

3.2 MUSIC THERAPY

The music therapy process of Thomas had four different stages:

- Single music therapy, from the age of 6 months to 12 months (17 sessions)
- Couple music therapy with Thomas and his nurse (4 sessions)
- Couple music therapy with Thomas and foster mother (10 sessions)
- Music therapy with the whole foster family (3 times)

I have evaluated some parts of music therapy process by the means of CARE-Index created by Patricia Crittenden. CARE-Index is the simplest and most versatile of the attachment measures. It assesses mother-infant interaction from birth to about

two years of age. It is based on a 3-5 minutes long videotaped material. The items of interaction that are observed in CARE-index are

- The facial expression (responsive, incongruous, hostile or angry, impassive),
- Vocal expression (warm, strained, angry, flat),
- Position and body contact (comfortable and accessible, intrusive, awkward),
- Expression of affection (affectionate, covertly angry, overtly hostile, uncaring),
- Turn-taking (within bouts of play) (positively contingent, negatively/punitively contingent, non-contingently uninvolved),
- Control (between bouts of play) (joint, adult, infant) and
- The choice of activity (developmentally appropriate, too demanding, understimulating).

These items work as a basis of video analysis I have made. In CARE-Index both mother and the child are observed. Because of the nature of therapy I must have, however, applied this assessment method. I have only used the items I presented to you and haven't used the scoring system. The setting is also a bit different compared to CARE-Index among other things because my job is to evaluate the whole process not only parts of it. When it comes to single music therapy I also realize that my main target is to assess the child not my own reactions. Though CARE-Index provides a good tool to reflection of your own work too. Today I am, however, concentrating on Thomas and his foster mother.

3.2.1 Single music therapy.

After Thomas had returned to the child care institution the single music therapy sessions were started once a week, 30-45 minutes at the time. At first the sessions were held in the ward where Thomas lived in, but were later on held in the therapy room which is located in the building next to the institution.

My first observations were that Thomas didn't make any eye contact although he looked at my face a little. He wasn't shy of me at all. On the contrary Thomas was laughing a lot, but my impression was that laughing wasn't connected to interaction. During our first meeting Thomas didn't turn around when lying on the floor, he couldn't sit and seemed to be less muscular than the other children at his age on average. When I was making funny noises and showed my tongue to Thomas he paid attention only for short periods. He didn't try to touch my face at all.

The next video clip I am going to show you is from our eleventh session. At the time of this meeting Thomas was 9 and a half months old. The first clip is about ten minutes after the beginning of our session. In the sample I am singing a song which is about the different part of our faces.

VIDEOSAMPLE 1

The facial expressions of Thomas were irritated and the boy didn't seem to be comfortable at all. He was making noises and was trying to say something – his babble had a meaning and direction. The position of Thomas was restless and he was more directed away from me. Thomas expressed his feelings and revealed that he felt uncomfortable. Turn-taking didn't occur and I had the control of the activity likewise the choice of activity.

There are two important questions raised about this sample. Why was Thomas so restless and why did I keep on going? First of all, it is possible that Thomas could have just wanted to do something else. Maybe he was bored or, as he in fact did, saw something more interesting that he wanted (he actually saw an egg shaped maracass beside us). What would I have done in a normal interactional situation? I would have of course stopped and tried something else. But this situation was a therapy session the targets of which are different. I knew Thomas had difficulties to let me touch his face and also concentrate on my face. So at this point I made a decision to continue the interactional situation as far as I could. These types of situations are one of the reasons why CARE-Index cannot be used as such to assess therapy.

The next sample is from the same session about ten minutes later.

VIDEOSAMPLE 2

In this second sample the facial expressions of Thomas were very concentrated. His position was calm and he took physical body contact. In the hiding-game we shared the joy and played together. I had the control and the choice of activity though I

was trying to take into consideration the acts of Thomas and get ideas from his behavior.

Significant in these two samples from the therapists' point of view is the differences we can notice. Thomas almost seems to be like a different child when we compare the interactional skills of him in these two clips. It looks like Thomas got used to me during the meeting, maybe even started to remember our way of being together. From this viewpoint the therapy can be considered an effective way to influence the interactional skills. The progress can clearly be seen already during one session. The question is though whether these interactional skills transfer into other relationships.

The ending of the single music therapy was a decision of many weeks of conclusions. I had serious difficulties at the end of process to always try to turn the face of Thomas towards me. The way I see the purpose of the therapy is that I can try to make substitutive attachment experiences, but the purpose is not actually to make the child attach to me. After all, I wasn't going to be his primary caregiver! The problem is how a child of this age can make the difference of these things. I had serious thoughts about the ethics of the single therapy. The final decision of finishing the process came to me when Thomas started to cry after the nurse had left him in the therapy room at the beginning of our sixteenth meeting. Though this cry of separation went over fast, maybe even too fast, it was a clear sign to me of the changed needs of Thomas. After discussions with the nurses of Thomas' ward we decided to experiment a therapy with the nurse and Thomas together.

3.2.2 Couple music therapy with Thomas and his nurse.

The nature of foster care is that the events are difficult to predict. We didn't know the schedule of Thomas' staying at the institution or the moving to a foster family when we started the couple music therapy with Thomas and his nurse. Therefore we had time to have only three meetings just between the nurse and Thomas. In two of these meetings the nurse was so-called Thomas' personal nurse. After the foster family was found there was one meeting in which the foster mother took part into and observed the music therapy session of Thomas and his nurse. If we could have predicted the fast finding of foster family this couple music therapy had not probably taken place at all and the single music therapy had continued as a couple music therapy with the new primary caregiver, foster mother and Thomas.

From Thomas' viewpoint these couple therapy meetings were not much of a use. The few meetings we had were however very useful if we observe my own learning. Already on our first meeting I realized that this kind of therapy is meaningful

because of the transferability. Once a week –meetings with the therapist don't remain in the mind of the child but if the same songs are played also in the ward in basic nursery situations achievements can be totally different. From the viewpoint of the attachment theory the presence of one same nurse would be ideal, and that would preferably be the so-called personal nurse. Music could work like a tool between the interaction of the child and the nurse and therapy meeting could be a moment of gold when the nurse could concentrate just on this child with his/her needs. And as you all can imagine those kinds of situations are rather rare within a common day in a child care institution.

3.2.3 Couple therapy with Thomas and foster mother.

A foster family was found for Thomas when the boy was fourteen months old. The family consisted of mother, father and three children – a ten-year-old boy, an eight-year-old boy and a five-year-old girl. All three children were foster children but they had moved into the family already in their very early childhood before they were six months old. The father worked outside the home and mother had stayed at home taking care of the children.

Like I already told you, the foster mother, who I here will call Jane, participated in music therapy as soon as the information of foster placement had been confirmed. Jane became familiar with the couple music therapy of Thomas and his nurse mainly by watching and listening. In addition, Jane and I had a session where we together watched over the videotapes I had recorded from music therapy sessions.

At our preliminary meeting we made a deal about ten music therapy sessions between Thomas and Jane and besides of that, three music therapy meetings with the whole family. We had an agreement that we would meet once a week and the family sessions would take place at the beginning, in the middle and at the end of the process. One session would last forty-five minutes.

Discussions with the foster mother became an important part of these meetings. The discussions took place unconstrained between other activities. Jane brought up the reactions of other children but mainly the discussions handled directly Thomas and the matters of his development. The lack of being afraid of strangers was annoying Jane in particular. This kind of behavior is on the other hand a respected quality of human nature at least in Finland but it raised feelings of helplessness on Jane. It's about protection from danger, one of the key aspects of the attachment theory – how to protect Thomas when he himself is not capable of doing it.

My purpose was to pay attention to the appearance of interactional moments of Thomas and Jane. I had an intension to create these kinds of moments and to give support to upkeep them by using different working styles. At the same time we tried to practice for example turn taking, concentration and waiting for a fun thing so that Thomas and Jane could have experiences of shared joy.

At the beginning of the sixth meeting of the couple therapy of Thomas and Jane I made a videotaping where the setting imitates the setting of CARE-Index. Because of the situation the toys were replaced by musical instruments but otherwise the setting was almost the same as the setting of CARE-Index.

VIDEOSAMPLE 3

As you could see the developmental progress of Thomas within six months was huge. At the time of this taping he was at the age of seventeen months. His vocal expression had a direction and he clearly wanted to say something. Thomas could express his feelings and you could notice purposefulness which is typical of his age. Thomas had a variety of facial expressions and he looked straight at Jane. Also the position was towards the mother. Thomas didn't seek body contact but despite that he took the stick from Jane's hand. Thomas seemed to have the choice of activity likewise the control. Actual interaction couldn't be seen.

Jane's functioning seemed to be normal, wouldn't you say? Although most of you couldn't understand a word you could say that her vocal expression had different shades and she expressed her affections. A variety of facial expressions could be seen and Jane had an intension to have eye contact with Thomas. It also seemed like Jane would have been ready for physical body contact if Thomas had wanted it. Jane had an intension to turn-taking and to the choice of activity but Thomas didn't go along. Altogether Jane in my opinion had a constant and good intension to be in interaction with Thomas. Her attitude was longbearing and she was ready to try to take contact time after time.

It seemed to me that the problem was rather in the differences of temperament of the mother and child. It looked like Jane was all the time a little behind Thomas and that she couldn't reach the same level of power when it comes to action. One example of this was the situation where Thomas played the drum with the stick. Jane was a little terrified about the loud noise and even said about that to me but the noise

didn't seem to bother Thomas at all. You maybe also noticed that Thomas played the clockwork with the wooden side of the stick but Jane's choice was the softer sounding rubber side. Jane wished to have feedback from me and we had a discussion of this session. I tried to encourage Jane to have more control on interaction and to have courage to meet Thomas at the same level of force in different plays. To my delight I could notice some changes on this matter already during our last meetings in music therapy.

3.2.4 Music therapy with whole foster family.

The meetings with the whole foster family included work with the different roles inside the family. The roles were observed in relation to existing interactional relationships but also through the changes Thomas brought into this system. The roles were reflected by picture making, improvisational playing, recording and listening and with the help of different contact making-plays and discussions. The purpose of these meetings was to pay attention to the family as a whole but also to everyone as an individual and as an important part of the family.

From the family's point of view I understood that the most important thing in these meetings was this doing together –thing. And the family was eager to take part in different actions too. The doing was, however, from time to time even chaotic and the children seemed to have a strong need to compete the attention of adults. I felt this was correlating with the new situation in music therapy but also caused by Thomas moving to the family. I interpret their improvisation to the family with these words: "Family life is from time to time quite a mess because the family consists of so many different kinds of people of different age. Sometimes there are, however, also more accumulated moments like at the end of the improvisation when a common rhythm is found."

4. The feedback from the processes

I got feedback altogether from six families who had taken part in the kind of model I have now introduced to you. The feedback was mainly about the couple and family music therapy meetings. According to the families they had mostly felt easy to be in these meetings. The meetings were told to be unconstrained and structured enough. One parent claimed that music wasn't the easiest way of expressing oneself and because the mother hadn't felt so relaxed in the sessions.

The families were satisfied with the arrangements though one parent told that the long trip had been difficult to organize to the family. According to the feedback forty-five minutes once a week seemed to have been good but even twice a week meetings were suggested. Different kind of meetings and family compositions had felt fine. One family found that it had been very good that they could have decided what kind of composition they would come to the meeting because they themselves were the experts to evaluate that. Many parents also stressed how important it had felt when brothers and sisters could also join the meetings.

According to the feedback from the families, music therapy had

- helped to get to know the child better
- decreased jealousy of the sisters and brothers
- given information about the time when the child was living in the institution
- given an opportunity to use the same songs and plays at home as had been used in the institution
- given means to develop the co-operation with the child and
- offered a place where it was possible to discuss with someone who had known the child during a longer period and get knowledge of the development of the child.

One feedback pointed out how important pre-information about music therapy is. The knowledge about music therapy methods was thought to be particularly important for the families who didn't consider themselves musical. Another family felt important that the therapist, at least in theory, was available even between the meetings by phone or email.

5. Conclusions about how the method works

Without doubt ethical issues arise when the question is about an infant living in a child care institution and having therapy. Is there any use of therapy while the foster- or adopt family is still on search? The process is very hard even to the therapist. The meetings are mentally but also physically very intense and therefore emotional bonds develop maybe stronger than in many other kinds of therapy processes. The feelings of counter-transference are also markable.

Music therapy which is carried on when the child is temporarily staying in an institution would have great benefit if the people from the ward could engage them-

selves in the process. In that case the task of the therapist would be to support and confirm the interaction between the child and the nurse. From the viewpoint of the attachment theory there is no idea to try to bring just another adult near to the child – the idea is to help the child and his/her nursing adult to attach to each other! The fact is also that a therapy process which is started during the child is temporarily staying in an institution is always a risk. The predictability is poor because no-one can know the exact length of the child's stay. And of course there is neither no guarantee that this model I have introduced can be accomplished.

I have personally felt difficulties in this model in many cases. In the meetings which the child is taking part together with his/her foster parent it has been very difficult for me to make myself invisible. In these situations the child is often much more interested in me, the familiar person, than his/her new mother. I am the one who is singing and playing and am therefore also more interesting than a parent who is perhaps uncertain about the whole situation. My own feelings of insufficiency have popped up especially when I have met the whole family at the same time. At least I have learned that the meeting times have been all too short for the families despite the age of the children. Extra time is needed so that a peaceful being together becomes possible. On the other hand I have thought about an idea of having meetings just with the adults. Perhaps in such sessions it would be better possible to verbalize and reflect things that have happened during the meetings where the children have been involved. This idea might even become true because one of my fellow workers is studying to be a family therapist. Co-operation with family and music therapy would surely be fruitful to all the participants.

All in all I have a feeling that despite all the weaknesses of this model there is a clue which is worth following. Because of this clue I hope and believe that the developmental work will be continuing in this phase which is so important for the child and the foster family.

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CHAPTER 59

*You choose, you lose. A
psychoanalytic music therapy
approach with mentally retarded*

*adults with psychiatric
disorders.*

Van Reeth, Ilse

Introduction

This paper introduces my work at a ward for observation and treatment of mentally retarded adults with psychiatric disorders. I will particularly examine two problems which frequently arise in music therapy with these clients. The first one is the difficulty that many mentally retarded people have in making choices and decisions. The second is their acting out reactions to the freedom provided by the therapeutic frame.

Description of the setting

The psychiatric centre Sint-Amedeus (near Antwerp, Belgium) has an admission ward for observation and treatment of mentally retarded adults with psychiatric disorders, such as conduct disorders, personality disorders, psychosis, depression etc. The ward consists of two units, of which one is open and the other closed. The maximum stay at the ward is about 1 year, but it can be extended at a related ward if further treatment is recommended.

Soon after a client's admission to the ward there is a "music therapy screening". During this observation session I try to estimate his musical experience and preferences, his capacity to play in a group, his assertivity and his musical memory. I attempt to gain a broad insight into the client's picture. The screening also serves as a mutual acquaintance and a presentation of the music therapy. At the end of this session, the client chooses for himself whether he will participate in group therapy or not.

There are two music therapy groups. Both have two weekly sessions of 45 minutes each. For one group I determined more explorative therapeutic aims, as the group members have a certain capacity of self reflection. The other group is intended for clients with less ego strength, who demand a more supporting and less confronting approach.

If after the screening a client chooses to participate in music therapy, I try to find out - together with the ward's therapy co-ordinator - which group is most appropriate for him. Due to the variety of psychiatric problems, these groups inevitably remain very heterogeneous in spite of the subdivision.

Whereas the setting of the ward is eclectic with behavioural therapy aspects, the music therapy setting is psychoanalytic. The clients' concrete guidelines are the following:

- freedom of speech and musical expression, although not simultaneously (i.e. not playing any instruments while someone is talking);
- freedom of speech does not include insulting other patients (this restriction was imposed after severe conflicts that threatened to result in physical aggression)
- no physical contacts (this is a rule of life at the ward and is repeated in music therapy).

Description of the problem

My work with these clients revealed some specific problems. In this paper I will focus on two of them: firstly, the difficulty that many mentally retarded people have in making choices and decisions; secondly, their acting out reactions to the freedom provided by the therapeutic frame.

The difficulty in making choices is most obvious in free improvisations. Soon after I started working with the clients of this ward, I learned that free improvisations in group sessions are far too difficult for them. For some clients, choosing which instrument to play is already hard to do. Playing together in a group even seems quite impossible, as many of them do not participate in the improvisation. If they do, acting out reactions such as leaving, yelling, throwing objects etc. are common. Clients with the capacity to verbalise their feelings, describe discomfort, anger or annoyance afterwards.

Very often these feelings prove to be related to the musical expression or actions performed by other group members. When questioned about this matter, clients appear bothered by the restriction of their own musical and psychic space by the way other clients take advantage of the freedom of expression.

E.g. someone played very loud and one client got angry, saying that it gave her a headache. She left the music therapy room before I could even think about discussing it with her. Her leaving made me feel frustrated because I couldn't stop her. Obviously this feeling was the projective identification with her frustration of being unheard in her musical expression.

These problems are complicated by the heterogeneity of the music therapy groups. In addition to their mental retardation, the clients' pathologies also influence their behaviour. Moreover, there are differences between clients in cognitive as well as socio-emotional development. One might even ask if group therapy is possible at all in these conditions.

Hypothesis

A possible explanation for the difficulty to choose is the clients having not sufficiently learned to choose and decide: their cognitive limitations and, more important even, the retardation or stagnation of their socio-emotional development inhibited the development of their capacity to choose. This can be reinforced by the environment (family or staff) when taking over the client's responsibility.

At adult age, these clients' ego proves incapable of containing neither the freedom of decision (i.e. the consequences of decisions), nor the confrontation with other people's freedom. Despite the (conscious) enthusiasm about the freedom of speech and musical acting, this freedom generates a great (unconscious) anxiety to which the poorly containing ego responds by acting out.

TESTING THE HYPOTHESIS BY LITERATURE

The capacity to choose is not an "all or nothing"-capacity: it grows in accordance with cognitive development. E.g. a 2-year old toddler is able to choose whether he wants bread with cheese or marmalade, but he is not (or not yet) able to decide whether he wants to go to the swimming pool weekly from now on.

It is my opinion that object permanence, which is obtained during the sensorimotoric phase as described by Piaget, is essential in choosing. The child needs a psychic representation of the desired object or the alternatives that can be chosen. In a later phase, when the child is able to think in a logical manner and understands the connection between cause and consequence, he learns to imagine the possible consequences of his decisions - up to a certain level. Formal and abstract thinking, necessary for making more difficult decisions, is obtained by normal children around the age of 12 years. With many mentally retarded people, however, cognitive development stagnates before this level has been reached. Consequently, we must not expect them to be able to make these kinds of choices.

Not only cognitive development is significant in the field of choosing; socio-emotional development might be even more important. According to Doñen it is possible to observe a discrepancy between the achieved level of cognitive development on the one hand and socio-emotional development on the other. This discrepancy is one of the reasons of conduct disorders or psychiatric disorders which lead to admission to the ward. Many clients manifest psychiatric disorders as described by Doñen in case of a stagnation or deviation in the first socialisation phase. The primary social bonds did not generate a sufficient sense of basic safety, which is necessary in becoming an autonomous person. We can observe psychiatric disorders related to a stagnation or deviation in the first individuation phase as well. Major separation fears (caused by the lack of basic safety) hindered the individuation process. This results in a conflict between two things: one is the urge for exploration and the consciousness of the power of one's own will; the other is the dependency on the caretaker.

The escape from choosing in a larger context has already been mentioned by Freud. He writes that the unconscious choice of not choosing leads to neurotic disorders, which offer the easiest solution to a psychic conflict in the economical way. The disease prevents the neurotic from choosing - and losing. Many of our clients are admitted to the hospital for reasons of "conduct disorders", mostly with an aggressive component. These (conduct disorders) are the client's reactions to situations that require a maturity he does not have and a responsibility he cannot take. At the basis of these situations we often find choices which are impossible for the client to make and which frequently deal with loyalty. The psychic conflict thus exceeds the client's strength and conduct disorders arise.

In this context, Fromm's opinion on "fear of freedom" can be useful as well. Fromm describes how fear of freedom can be understood as a fear of loneliness; one that is inevitable as the person undergoes a process of individuation. The more the primary bonds are broken - as a result of the child's physical, psychic and emotional strengthening - the more he will be on his own, separated from the others, responsible for his own actions. Those of our clients whose growth was delayed and didn't lead to sufficient ego strength, are not capable of dealing with this responsibility. (Exploring the origins of this would lead us too far, but of course we can wonder which part the upbringing environment plays in not breaking the primary bonds.)

According to Lacan, the concept of choice is essential in becoming a Subject: the impossible choice between the Being and the Sense. This choice, however, rather is a kind of "your money or your life"- choice. There is only one solution: choosing

your life, and giving up all your money for that. As far as the Being or the Sense is concerned: one must choose the Sense, which brings a "lack of Being" with it.

The capacity to choose is related to the unconscious desire, which can only exist if the Subject has effected the symbolisation of the second level, thus: if the Subject has adopted the language as a metaphorical system. We notice an insufficient adoption with mentally retarded clients.

Rather than developing his own desire, the mentally retarded person stays in the position of meeting the Other's desire. He exists as a fulfilling object of the Other's desire. Leaving this position requires the capacity of mentalisation. Therapeutic reality shows us that our clients lack this capacity.

The capacity of mentalisation is also the clue to the acting out reactions. The musical expression of other group members, often fierce and not hindered by a controlling and regulating Ego, has a certain impact on the client. He cannot "experience" it, there is no signifier. In short, it leaves the door open through which the Real sneaks in. In an acting out reaction, the client slams this door shut, or at least tries to do so.

Therapeutic work with these clients often reveals a past of "passivity" as far as decisions are concerned. Because of the initial refusal to choose and their tendency to let others decide, mentally retarded persons plant or grow the idea that they have no capacity to choose at all. Family or staff (educators, mentors, teachers, doctors etc.), mostly with good intentions but maybe unaware of their own unconscious drives to install a relationship of dependency, reinforce these dynamics by taking over the client's responsibility instead of helping him to learn to choose.

In the last few decades, however, the prevailing pedagogic opinions have increasingly emphasised the importance of choice and participation for these clients. During my supervision I've become aware of my personal "standards" on this subject: I wanted my clients to have participation, I wanted to take them seriously. This is one of the reasons why I let clients decide whether they participate to music therapy or not. But maybe, at the moment they are admitted to the hospital, they aren't able to make this kind of decision yet...

The value of music therapy

It is my opinion that a central concept in music therapy is "containment" the way Bion formulates it. In musical improvisations the music therapist performs the containment function, in expectation of the client's growing capacity to cope with the originally unbearable feelings. Guiding the client in his growth to containment is essential for the development of some sort of mentalisation that is necessary for making choices.

Furthermore, music is a very appropriate medium to practise the making of choices. The choice of an instrument or a way of playing have few if any consequences: the consequences of this choice do not last longer than the end of the session, and mostly not even that long. The client can also reconsider his choice of participation in music therapy.

Structuring the improvisations is often necessary in the first period. Mary Priestley's opinion on musical structure in improvisation is that it can partly take the place of the ego's synthetic functions. It seems, she writes, that when a certain structure is advocated in analytical music therapy, it allows the client a superego cleavage whereby he accepts the boundary of a given structure as a partial superego. The musical structure releases the patient's own hold on some of the repressed material and allows this to surface in his mind during the improvisations with or without it being expressed in the music.

In this context, the task of the music therapist is to steer a path between no matrix for expression and a structure that is crippling rather than enabling.

In view of the problems generated by the making of choices, in my approach I developed a strategy which, starting from a certain restriction (by means of a structure), gradually increases the freedom of choice. At the same time the clients are supplied with "musical tools", which they can utilize afterwards to form their (free) musical expression. Supplying musical possibilities I try to meet the client's often minor initiative of exploration: there is no own desire, so why explore the world? This brings us to the containment function again.

This strategy will be illustrated by means of the following case study, which describes music therapy with a group during 8 weeks. The group members have a certain self reflection capacity. As described before, there are two weekly music therapy sessions of 45' each; one session is for active music therapy, the other is for listening to music. Not all sessions are described.

Case study

Due to several circumstances only 2 group members are present during 8 weeks. Then one of them is redirected to individual therapy for specific reasons, so there is only 1 person (a young woman, K.) left in the group. She enjoys this unexpected “individual” therapy.

1.

After two weeks, another woman, D., joins the group. The 2 women have the difficult relationship with their mothers in common. Furthermore, both show little empathy to the other group member and they struggle to get the therapist’s attention. They are not able to play music together: each one plays on her own and there isn’t any connection or coherence.

As the clients clearly do not experience any support or satisfaction in these improvisations, another approach is chosen: dyadic improvisations during which the therapist plays together with one group member at the time. The clients choose the instruments they play. During these dyadic improvisations, the non-playing person – alternately K. and D. – manifests particular behaviour such as a theatrical pretension to be asleep, stealing a pen from my desk etc.

Group improvisations, even with only 3 persons, seem to be impossible for these clients. They are too much involved with their own concerns to listen to each other – and so is their mutual musical response. Maybe the confrontation with “the Other being different to the Self” is too frightening. In dyadic improvisations (in which I play the supporting role), both clients appear to be more at ease. It feels like a moment of comfort in a turbulent day. However, it is remarkable how they cannot bear the therapist paying exclusive attention to the other group member.

2.

A third woman, N. joins the music therapy group. She is suffering from alcohol abuse in a troubled relationship with her children, of whom one is autistic,. She usually starts the session by saying that she’s having a hard time, that her head aches and that she is not good at making music.

The next session only K. and N. attend to music therapy. N. (the client having difficulties in being a mother) enters the room saying she has a headache. K. (the one having difficulties in being a daughter) says that she feels bad, that no one understands her, no one cares for her etc. She wants to leave the music therapy room to “take a breath outside”, to go to the toilet, to wash her hands, in short, for any think-

able reason. She wants to return to the ward and her constant complaining and yelling makes therapy impossible. In spite of my usual approach I intervene in a directive way and subsequently K. stays with us, although not participating in the improvisation.

As N. – who claims her headache has increased by the yelling – does not want to play any instrument either, I play the piano while the clients listen. Doing so, I intend to reinforce or emphasize the transitional space within which the music takes place; I let the music itself invite the clients to participate.

3.

In the following session, K., D. and N. are asked to play solos with a certain metre. K., very sad this time and crying instead of yelling, at first does not want to play. After having left the room for a moment, she participates in the improvisation. The structure of the improvisation is as follows: every participant picks out a “drum” (any membranophone). I start to play a metre; the clients improvise with it alternately. The available time per person is restricted to 2 bars. Unexpectedly, the clients add more structure to their improvisations, like repeating a small rhythmic cell.

The therapist playing the metre and counting from 1 to 8 (2 bars in 4/4), serves as a support. The restriction of instrument choice and improvisation time is meant to reduce the freedom, and as a consequence the fear of playing. The instant effect (the structure added by the clients), although surprising me, seems to prove the value of this approach.

4.

The following session is the weekly receptive music therapy session. We use 4 pictures of the “basic emotions”. Every client gets a coloured card which has to be put together with the picture in accordance to the music; we listen to various pieces of music.

The task invites the clients to focus on the emotional aspect of music. Moreover, the music is performed by others and as a consequence, it expresses an emotion that is possibly not theirs at that moment. This task reveals the problems that some mentally retarded clients have in linking music to emotion and in imagining other persons’ emotions. Maybe there is not enough theory of mind?

5.

In the next two sessions, two new group members join the group. E. is a young woman who is still her parents' "little girl". R. is a jealous man with aggression problems towards his partner.

6.

N. starts the session by saying she has a headache. I propose an improvisation on melodic percussion instruments (because they sound softer). D., who planned to play the conga, gets very angry and leaves the therapy room slamming the door. Subsequently she paces up and down in front of the windows so that we can see her. We play the melodic percussion instruments (there are 6 of them and all clients pick out one rather easily); during the improvisation we vary musical parameters such as loudness, tempo, number of notes, range etc.

After that, I propose that everyone freely chooses another instrument. This appears rather impossible – both clients keep doubting – so the range of choosing possibilities is restricted again: they have to pick a "drum" (membranophone). Both clients do so. Then we make an improvisation in which I start with a metre which has to be copied (as well as possible). Afterwards, I propose various ways to play cloaked in a game: a small contest of playing loudest, softliest, slowest, fastest, like a robot, a loony. We continue the game but this time the clients propose the ways to play.

N.'s headache keeps the other clients from choosing freely. We observe different reactions with the other clients: K., E. and R. find it easier to pick an instrument out of 6, while D. cannot stand being restricted. She is not able to verbalise this and leaves.

Proposing various ways to play, I want to help the clients to discover some of the possibilities offered by music. The aim is that afterwards – i.e. after a long period – they will make use of these "musical tools" to build an improvisation themselves.

The next step is the clients proposing how to play in a game-like improvisation: as they focus on the "game" they feel free to make use of their imagination and creativity.

7.

The clients are invited to illustrate a story by sounds. Every character in the story is presented with a specific instrument, and the events, emotions etc. are all played by the group members. They have a lot of fun doing so and they dare to exaggerate the expression of the characters' emotions.

The story enables the clients to express emotions using instruments without getting overwhelmed: it is a role they play, a story, not their own feelings.

8.

In the last session of this case study – the work with these clients has continued since then – the group is invited to make a free improvisation. Although they still need some verbal support of the therapist, they succeed in choosing an instrument and playing without the therapist telling them what to do. The major part of this improvisation is rather chaotic, but once in a while some measures of interaction (by means of a common metre, adaptation of one's own volume etc.) occur.

It is evident that we cannot expect the clients to fully accomplish the huge task of second symbolisation in such a short period of time. However, the scarce moments of really playing together in a free improvisation prove that they are able to enter the position of Desiring Object. Moreover, the clients encourage me to continue my job, for they are fascinating and gratifying to work with.

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CHAPTER 60

*Steering a path through change;
observations on the process of
training*

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**Symposium II: Aspects of the Music
Therapy learning and teaching
experience in the UK**

Students these days tend to be very much better informed than I was, when I applied to train as a music therapist. There are enough books to read and enough introductory courses to attend to find out what music therapy is. But even the best prepared student can be challenged by the amount that the training will change them personally. Through the process of learning to help other people to change, they must also be helped, and change, themselves. One student told me; 'I think change is in itself frightening for people. We cling onto our weaknesses as much as our strengths because they define us. I think there is a fear ... of a loss of identity.'

In this presentation I will be thinking about the challenges that students face when they train, and how these challenges provoke change. I will start this presentation with two quotations about change.

'Men do change, and change comes like a little wind that ruffles the curtains at dawn, and it comes like the stealthy perfume of wildflowers hidden in the grass.'

(John Steinbeck, *Sweet Thursday*).

This first beautiful quotation is from John Steinbeck, who wrote so much about change and internal struggle. I like this quotation because it seems to me that change often *can* come like a little wind that ruffles the curtains at dawn or like the stealthy perfume of wildflowers hidden in the grass. Perhaps it comes upon us in a way that seems very insignificant or for a reason that we cannot identify. Perhaps for each of us there are moments hidden in the experience of training that trigger a change in us. We may only realise the impact that this change has had on many aspects of our lives or our work when we look back. And many of us feel the need to carry on our personal development to continue the change that the training has begun.

My second quotation, from a final year music therapy student, holds all these thoughts and ideas.

'Change takes time (usually). Sometimes it comes unexpectedly when one stops trying to change and takes things easier. Things might change in us so subtly that it is difficult to realize that change has taken place... It takes courage, strength to change something unpleasant or something that burdens you. Change can be creative and cathartic, could imply progress. On the other hand sometimes when we change we leave something behind, we also have to make some sacrifices or compromises.'

Very little has been written about student experience during music therapy training, and yet it is something important to know about. Perhaps as students or newly qualified therapists, we don't feel confident enough to write about our experiences, and

as we become more confident, we are further away from the experience. Perhaps it is also important to consolidate some of the intense experiences we have had during training, before trying to put pen to paper. Judith Webster, writing in 1992 in the *British Journal of Music Therapy* said that ‘Music therapy training unlocked the door to a world of self-awareness and self discovery which I had never imagined to be so revealing, so painful but also exciting.’ 1988 (BJMT Vol 1 No 2 p18).

I imagine that this quotation has resonance for many of us. How many of us, when we began our training, were aware of what we had ‘let ourselves in for’? As I wrote this presentation, I began to think back to *my* experience of training. My training at Roehampton provided me with many profound experiences – some difficult, some positive. I’m not sure that I made sense of some these experiences for a long time... And now, I have both the privilege and the challenge of training students at Roehampton, and I witness many changes in students. Sometimes training is a difficult process; at other times it seems that students embrace and revel in their change.

Through my experience of teaching, I have become particularly interested in the way in which students experience change during training, and how the tutor has a role in this change and can enable it most positively. How does the teaching and facilitation, and thus the learning, on a training programme, have an impact on student change? Over the past few years I have asked some students these questions and I am very grateful to be able to use their responses in this presentation. I would like to consider some of the challenges that students experience during their training that can provoke change. I’ll refer, as I go, to some theories of learning and teaching that might help us to understand the student position.

The kind of learning that takes place on a music therapy training is personally challenging in many ways. It involves taking in new knowledge but it also involves consistent challenges to the student’s own conceptualisation of their world. We are a reflective profession, deeply engaged with change in our work; it is inevitable that becoming a therapist will involve change for ourselves. I hope that as you listen, you will be able to engage with this presentation as having relevance to you; whether newly qualified and close to the process of training, or a therapist of many years experience, for whom the memories of training are faded.

In the UK, training courses have, over the past 15 years, changed significantly. We are now state registered and there are professional competencies which music therapists must meet, and thus a comprehensive syllabus to be studied. Our students must, of course, develop their musical skills in order that they can use their music to help their clients, and must develop a sound therapeutic approach. But there are also other qualities that all therapists need. Both McConaughy and Rogers talk

about the person of the therapist in clinical practice. We need to be genuine, caring and have empathy. We must be self aware and self accepting (though not perfectly analysed...), have a solidly structured sense of self, and a wish not to become a 'finished product'. When we think of this, we can see how much the tutor and the student share the responsibility for student development and change. Tutors can dictate what a student must know about, but the student must be motivated and able to develop their own personal qualities.

And every student who embarks on a Music Therapy training is unique. Each student brings extremely different knowledge and experience; personal, academic, musical and their work with different groups of clients. Students have told me how their work experience and personal experience has provided them with useful knowledge to bring to the training; one student stressed the way in which her engagement with music had given her a creative resource that could sustain her through challenges and difficulties on the training. Students are encouraged to share and use this personal and work experience and knowledge in order to engage with, and make sense of their learning.

On a music therapy training we learn in different ways. There is a lot that we have to learn *about* (child development, child psychology, psychiatry, and theory – both of music therapy and at Roehampton, of psychoanalysis). This kind of knowledge, knowing *about* things, is termed declarative by John Biggs (1999). But we need students to have functioning knowledge as well; this means knowing how and why to do things. So almost immediately, we plunge students into experiential learning. On the Roehampton course, in the first term, students go out on visits to different workplaces, and learn straight away about how they might need to react in difficult, sometimes painful or awkward situations. Students begin their clinical improvisation classes and have to struggle with the challenges of trying out a new way using their music differently, often observed by other students who offer (mostly) well meaning constructive criticism. Students have to find a mother and baby to observe, an experience which can bring up memories of their own early lives. Importantly, they must also find their own personal therapist. In the second term, students embark on their first clinical placement. They are immersed in a wide range of different, intense experiences.

When students realise that they are required to explore their own ideas and construct their own knowledge, as well as learn through lectures and seminars, and when they realise that change and the unknown are welcome, they can begin to feel less, rather than more sure about what music therapy is and what they are embarking on. They can also feel worried when they realise there are no definitive answers to all their questions. *Tutors* may even sometimes say that they 'don't know'.

John Woodcock's observation is apposite here. Talking in 1992 in the BJMT debate about priorities in training, he says: 'Change is inherently painful, as well as joyful, even the change in one's concept of what music itself is.' (BJMT Vol 6 No 2 1992 p23). And Elaine Streeter, writing about experiential music therapy groups reminds us that 'there are some profound experiences of loss (as well as growth) involved in training to be a music therapist.'

Do music therapy students also feel this sense of loss and growth about the process of training? I would like to read some responses from students where they speak of the painful or difficult parts of the process, as well as the ways in which they feel they have changed positively as a result of the training. Some of these quotations allude to the way in which the training reaches right into our personal, private lives.

One student said; 'Confronting difficult things from my past in personal therapy was difficult but proved a very worthwhile endeavour. Conflicts in training group were also challenging but ultimately helped me to learn more about myself. ... As I started to look at difficult feelings arising from my own life, and to think about the difficult feelings of clients, I felt more vulnerable and fragile. As a result I gained a considerable amount of weight through comfort eating. ... As a result of the process, I got rid of things in my life which were not healthy – especially relationships and habits which no longer served me.' This student added that: 'I now take more care of myself physically, psychologically and emotionally.'

Another student wrote; 'I think I might be less 'fun' than I was a couple of years ago, but this probably comes with greater responsibility... might be a question of maintaining a balance in the future. She added that 'I am much more self-aware. More confident and expressive, with greater sensitivity to other people's feelings in my personal relationships. Greater understanding of negative/destructive elements of relationships and able to deal with them better. I think it's surprised me how much I (and other students) have changed and so I think I'm more aware of the possibilities for change in other people.'

A third student talks about her steady, gradual process; 'My learning has been very gradual. My understanding has gradually increased as the course progressed. I feel that the journey has been growing into a therapist rather than just becoming one, and will continue as and when I work. It isn't at all about facts. Everything I have learnt on the course is new. I feel like a blank canvas that has absorbed the experience of the past years... And this student gives us a warning too – that using psychoanalytical theories in personal arguments is not recommended! I partly mention this last part of the student's response because the way in which our personal lives are affected by our training is significant. Students may be concerned by the way in

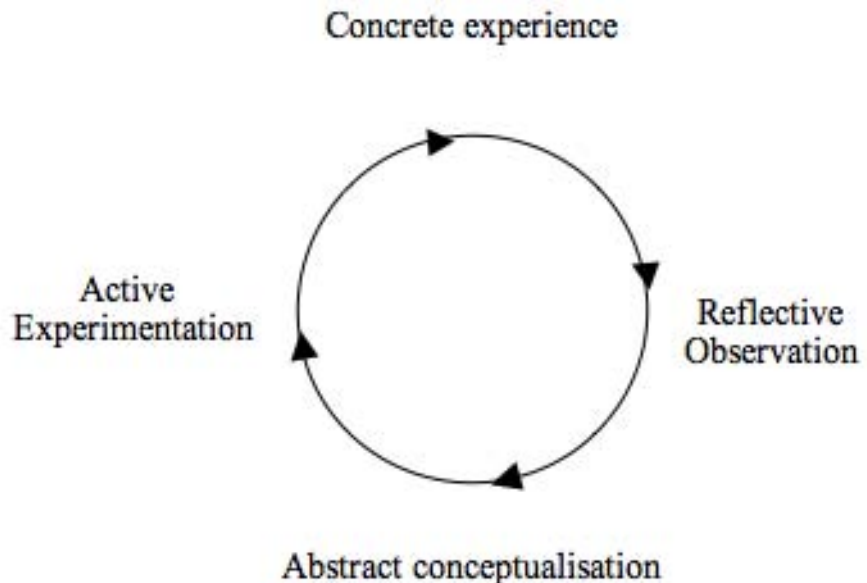
which their newly acquired vocabulary, ways of thinking or personal growth, mean that they no longer fit in so comfortably, or in the same way, with groups of friends, family or even partners. Rachel Darnley-Smith talks about this in the *British Journal of Music Therapy* in 2002. 'Trying to speak this new therapy language with old friends and family was not a success. 'Music therapy' sounded very interesting, but a therapist who talked about herself and her feelings, as well as the work she was doing with clients, provoked responses along the lines of 'we're not in one of your sessions now'.'

Perhaps we can all remember how difficult it was to try and integrate this new way of being, thinking, seeing things, responding to situations. Friendships are tested, relationships fall apart, family wonder what on earth has happened to the sister, daughter that they knew. It takes time to find a way of including our new knowledge in our everyday lives.

I asked my students what was striking for them about the way in which they were taught. It seems that students often find that the way that they are required to learn is very different to their previous experiences. One student said: 'Much of the training had to be experiential which was very different for me. There was also much more student participation in talks and lectures. This training was much more of a personal journey or process. Nothing I have done before has involved so much personal development and reflection on one's own feelings and responses.'

Experiential learning is essential on a music therapy training, and I would like to speak more specifically about this now. This kind of learning has been described by theorists for many years. Kolb (1984) drew a learning sequence, or cycle, to show how he thought it worked. Many theorists think that experiential learning is the most useful type of learning in all types of situations, because students are active, taking responsibility for their own learning, and can relate and apply it to their own experiences and context. The phase of reflection is felt by some theorists to be the most important.

FIGURE 1. Kolb's learning cycle



Actually another theorist, John Dewey, thought about this process as a series of spirals rather than a circle. Each spiral, or episode of experience, allows potential for change and growth. Interestingly, Dewey also thought about timing, and how it was important to have time to consider one's experience, but not so long as to become stale. As tutors, we are often debating the right time to introduce a new idea or experience; a little as Winnicott thought of object presenting. And we know as therapists the difference that a break, a pause, can make to the therapy process.

In 2003 I completed my post graduate certificate in learning and teaching in higher education. This was an interesting undertaking, because it meant that I was a student and a lecturer at the same university; in the position of student and teacher at the same time. I studied theories of learning and teaching, in order to apply them to my work with students. Perhaps, looking at Kolb's learning cycle, some of you are making the links that I kept making, throughout my study. Theories of learning, especially experiential learning, echo the process of therapy. Should I have been surprised to find the words and ideas of Yalom, Bowlby, Bion, Foulkes and Rogers scattered among the pages of my text books as I studied? Therapy, after all, involves learning - about oneself.

Someone who brought together thoughts about therapy and learning rather neatly is Carl Rogers. As therapists, we tend to know about the part of his work which he termed client-centred therapy. However he also thought a good deal about teaching and learning. Some of his 10 principles of learning, rather paraphrased, have much to say to us as Music Therapists, as well as to students and tutors;

- Learning which involves change in self-perception is threatening and tends to be resisted, hence learning is more easily achieved when external threats are minimised and experience can be processed safely.
- Learning is facilitated when the learner participates in the learning process and much significant learning is achieved by doing.
- Self-initiated learning which involves the whole person, feelings as well as intellect, is most lasting and pervasive.
- Creativity, independence and self-reliance are facilitated when self evaluation is primary and evaluation by others is secondary. (Brockbank and McGill p148)

My students' responses support these ideas. When asked what helped them to move along their process of becoming a music therapist, students said this;

'Getting out to my placements and experiencing theories in a 'real' clinical setting brought them to life for me.'

And '[The] experience of the idea being translated in the actual therapy work [has helped me to change]. Sometimes one needs to see or feel something happening before one can take it on board.'

'I can remember, at the beginning of the course, experiencing at first hand how the mother/infant relationship relates to the therapist/client relationship, and how this helped me to move along the process of becoming a therapist.'

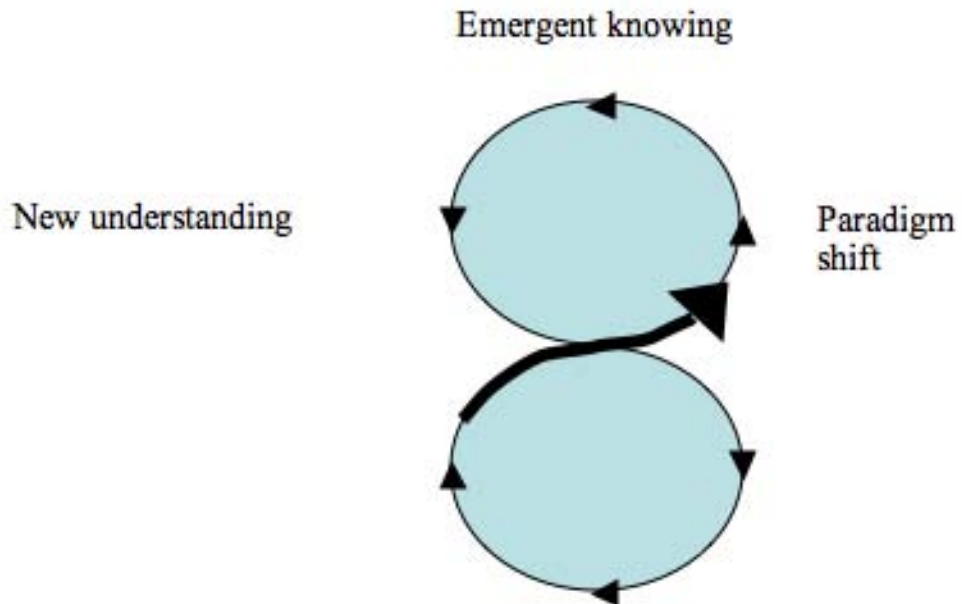
So experiential, personal learning is very important to the process of change. But this kind of learning also carries with it risks and difficulties. Students also told me about their need to feel safe enough to take risks – and the difficulty of feeling judged. Talking about one experiential learning module that focuses on the clinical use of music, students said 'I wish I'd been braver', and 'I wish I'd taken a risk' These students' honest answers helped me to think about, and develop the ways in which I can better support their process of change. Perhaps paralleling a therapy group, it seems clear that this kind of student learning session must feel safe and supportive if students are to be able to make themselves vulnerable, expose their worries and areas of weakness, and learn from others.

So why use experiential learning if it can be so painful? What does experiential learning allow students to do? As our students have already told us, it helps them to bring learning to life; to construct their own meaning and thus learn 'deeply'. I would like to speak more specifically about this for a moment.

In teaching, there is often a moment when students get to grips with an idea, and need to try out their knowledge. This might be the point in a seminar where I ask if there are any questions. Someone is brave enough to say 'is it like this?..' and state their own understanding. Or, we are in repertoire group, where the students bring musical difficulties or problems from their clinical work. We have thought about a student's problem and I ask for someone to role play the therapist and the client. There is a silence, and a couple of students are brave enough to say 'yes, I'll have a go'. Or we are thinking together in supervision and a student bravely makes a link between a theory and some case work.

Students need a feeling of safety in order to engage in this process. They are taking risks, journeying outside their realm of experience to develop their understanding, make links and construct their own meaning of a concept. They are, in the process, making a change to their knowledge and sometimes their attitudes and beliefs. I like the concept of 'single and double loop learning' that describes this (Argyris and Schon 1978).

FIGURE 2. single and double loop learning (Argyris, C, and Schön, D 1978)



Double loop learning involves learning from mistakes and in the process, questioning and modifying underlying ideas or beliefs. It enables a personal learning shift, allowing students to journey further in their development. Here we find another link with therapeutic theory; this idea links with that of Foulkes (1964), a group analyst, who described the idea of a 'reflective loop', where patients in group therapy can journey outside their area of comfort, and come back to the group, having been supported in learning something about themselves. Students who are used to more didactic teaching can be quite unfamiliar with this type of learning, and need support to develop their confidence and skills in this setting.

When students take a risk and contribute to group learning in a way that links their learning and their experience, they are making a transition from declarative to functioning knowledge. But this process can be tinged with anxiety. Savin-Baden, an Occupational Therapist by profession, terms this part of the student process disjunction. She defines this as 'A sense of fragmentation of part of, or all of the self, characterised by frustration and confusion, and a loss of sense of self. This can result in anger, frustration, and a desire for 'right' answers.' (p87 2000). Disjunc-

tion can occur as students are in transition, learning about new concepts and ideas and making sense of them from their own experience. And tutors are not always able to provide students with 'right' answers, particularly in relation to their clinical work.

Savin-Baden feels that if students don't resolve disjunction positively, the issue that caused the disjunction will continue to inhibit their progress. There is, again, a parallel with therapy here. Savin-Baden identifies, and I have observed, different ways of resolving these difficult feelings; retreat (don't engage with it), temporising (postpone engaging), avoidance (find a way of getting round it), or engage with it; usually through a reflective process. To illustrate this, I would like to read an extended quotation from one student, who looks back on the difficulties she experienced during her training:

'Change is the stuff of life, but it also involves loss and it still feels painful. I think a significant change must have been at the end of the first year, when I argued about a mark – a lot of my self confidence was held in the idea that I was good at this subject, and if I was not recognised, what must I do with my self-concept? I nearly dropped out. Not there and then, but through the long, silent summer. Change this big feels like dying. It is so painful, almost anything else would be preferable. My tutor said to me in assessment 'you either understand straight away and well, or not at all. You need to find a way of making it all, right *enough*, a middle ground that's good enough.' In the end, I recognised that the fantasy 'I'm brilliant really, I just need to find the right context' covers the fear; 'I'm crap, really. And people know it.' – and the change is to realise I'm neither – what a relief to find that I'm ordinary... but what pain and loss too. I feel more boring now. [At the time] I was furious. For a long time I maintained (and on some verbal level it may be true) that my tutor had misunderstood me. But the fact remains that she put her finger on *exactly* what the problem was.'

This is an example of how an assessment can touch on deeply personal issues that must somehow be addressed and resolved between tutor and student (and probably in personal therapy). This student was being asked to address a deeply held, keenly felt ambivalence; am I brilliant or am I crap? She talks of retreating (thinking of leaving), avoiding (my tutor has misunderstood me) and then of engaging, and of managing a change that might ultimately help her to help others. I find this honest account moving and convincing evidence of the challenge that students take on when they engage fully in the training process.

It may not be possible, nor desirable (as in therapy), to make things feel alright, or easy for students. But it is important to hear and learn from students about what

supported their process of change. As might be expected, individual students identified different elements of the training as being most supportive, but supervision was frequently mentioned;

‘The most profound [teaching support] has been a couple of key moments in supervision when I was made aware of things I was doing in the sessions that I wasn’t aware of. This has led to very definite changes in the way that I work.’

‘I think supervision has made a great difference, helping me to move along.’

This emphasis on supervision as being identified as a key element of teaching and support underlines the importance of the UK post diploma supervision scheme, and of supervision for all our development.

Students also talk of their personal therapy providing them with an essential place for reflection, and to make sense of some of the disjunction that they are experiencing. One of my students, talking about personal therapy, said that; ‘it supported me during difficult times, and helped me to face some of my difficulties. Moreover it helped me to acknowledge some of my needs. It also helped me to become more patient as a therapist, since I saw within myself how difficult it is sometimes to change certain things.’

We teach a syllabus that includes all that is required of us by the UK Health Professions Council, and that includes all that we feel trainee therapists need to know, and still we require something extra from the student. We want them to learn what *they*, personally, need to know in order to practice as a competent therapist – and this personal learning is different in each case. We thus encourage students to reflect on their process in the training and to address areas of weakness.

As a tutor, I cannot make this process easy, as perhaps at times it was not easy for me, but I continue to work to support students in the best way. I am always inspired and impressed by the hard work of students on their personal journey towards becoming a music therapist. It is my conviction that it is now time to involve students and tutors in in-depth research and study into this complex area of pedagogy.

I would like to end as I began, with two quotations. Firstly, T S Eliot from the Four Quartets, to which I was introduced by Andrea Clifford, when I was training;

‘We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time

Lastly, a quotation from a second year student about to take his final assessments;

‘I think I welcome change more now. I used to be very frightened of, and resistant to it when I was younger. I now feel that it is not only easier to manage change in my life, but that change is an exciting and desirable part of a full life. Change for me was always experienced as a difficult loss. I now see it as an opportunity for growth and development, not to mention adventure!

I would like to acknowledge and thank the students who have generously shared their experiences

through the completion of questionnaires

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CHAPTER 61

*Good vibrations: musics impacting
child bedtime milieu behavioral
patterns*

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Decreasing child patient anxiety around bedtime, especially when it leads to aggressive behavior, is an ongoing issue in many hospitals. This study examined the use of planned music interventions for assisting patients to be less anxious at the bedtime hour, therefore, reducing patient aggressive behaviors resulting in therapeutic holds and/or restraints. Key terms: acoustical design, inpatient children, psychiatric hospital, Vagus nerve, music

*Observations based on “everyday” sounds in
hospitals*

Sound/noise studies in hospital settings has been studied increasingly over the past decade, with particular interest in medical hospitals given to neonatal intensive care units. As a result, equipment modifications have been made because of inappropriate decibel levels; staff traffic patterns have been altered; and care-givers' aware-

ness has been heightened as to loudness of "voice levels" at certain times of day and night. Psychiatric hospital settings have most often been studied for sound/noise levels information mostly around the issues of agitation in elders particularly related to "sundowners" phenomena. Since 2000, the number of journal articles that discuss the impact of noise (ambient sound) on patient care has slowly increased. PubMed catalogs seven titles from 2000-2002 but approximately one per year prior to 2000. Architectural interests have also grown albeit incrementally over the past three years.

Susan E. Mazer introduces the obvious in her article Sound Advice: Seven Steps for Abating Hospital Noise Problems (2002). "If we take for granted that hospitals are institutional and designed to be "one-size-fits-all" kinds of places, then their physical character can appear to be generic. However, while the hospital environment is most commonly thought to be about beds, walls, windows, floors, ceilings, and technology, it is also about people, clutter, and noise. In fact, according to patient satisfaction surveys, the quality of the healthcare experience is often evaluated according to the quality of the hospital's dynamic environment, which is circumstantial and changeable." Mazer continues her discussion by describing seven steps for defining a more "patient friendly" ambient environment.

- Step 1: Assess the Sound Environment
- Step 2: Establish Sound Standards
- Step 3: Establish Equipment Maintenance & Purchase Standards
- Step 4: Make Decisions About Patient-Appropriate Equipment
- Step 6: Design Areas for Sound Control
- Step 6: Educate Staff
- Step 7: Measure Results

The second Congress of the International Academy for Design and Health Congress held in Stockholm in 2000, provided an opportunity to raise several questions on many of Mazer's suggestions. One particular paper at the Congress, presented information related to the likelihood that ambient sounds found in a psychiatric hospital setting could be triggers for negative behavior in patients (Wesley, 2001). It also presented particular music therapy strategies that were designed for maximizing therapeutic intent and decrease specific behaviors for selected patients. The study suggested that environmental or ambient unit sound is likely overlooked as a patient stressor and therefore, was not factored into treatment planning.

Auditory over-stimulation is an especially valid concern given the premises of Porges' Theory of Social Engagement (1998). This theory links the evolution of the autonomic nervous system to affective experience, emotional expression, facial gestures, vocal communication and contingent social behavior. It is sometimes referred to as the "Polyvagal Theory" and proposes that the evolution of the autonomic nervous system provides an organizing principle to interpret the adaptive significance of an individual's affective processes. Most importantly, in a particular physiological state the range of behavior is linked to psychological experience for the individual. The Vagus Nerve or Cranial Nerve 10 (CNX) is 80% afferent although it is more commonly regarded for its efferent (20%) influence on human functioning. In order to understand the "job description" of CNX it is important to know that its Sensory Branches include the meningeal, auricular, pharyngeal branches and the internal, external and recurrent laryngeal branches and the Visceral branches of the Vagus include the aortic arch baroreceptors, heart, lungs, and abdominal organs.

(insert chart a & b side by side)

Informed specifically by his work with trauma survivors and the Polyvagal Theory author and clinician John Chitty has provided further clarification of Porges' work. Chitty refers to his integration of information as the "The Triune Autonomic Nervous System" and emphasizes a Phylogenetic view of the vagus as it pertains to the evolution of living organisms in general and humans in particular (2002). Keep in mind that the Autonomic Nervous System (ANS) is the neuro-endocrine-immune structure that enables survival and has two branches: parasympathetic (rest/rebuild) and sympathetic (fight/flight). The third of the "triune" is where Chitty aids the understanding of the Polyvagal Theory. "Porges has shown clear evidence of a third, more modern branch of the ANS, with a survival value specific to more sophisticated animals especially primates "Social Nervous System" is the proposed term for this third branch of the ANS." Further, Porges' research shows that under stress, the human system tries its newest system first. When that fails the next older system comes "online". As the system of last resort, the parasympathetic resources are employed. Under stress, therefore, the order of survival strategies goes: (1) social/relational; (2) fight/flight; then (3) immobility. Chitty has also documented, through his clinical work, that in the case of human trauma, the capacity for using newer strategies can be eroded with the older strategies becoming the normal response.

Patient responses to hospital sounds

An eight-week individualized Music Therapy plan incorporating premises of the polyvagal theory, was developed for three patients, in order to reduce their assaultive behaviors. The three boys were referred because of their observed enjoyment of some music activities and the severity of the aggressive behavior. The hypothesis was that if a patient's "memory menu" could also include substantial positive associations based on organized auditory input or music interventions/experiences then the patient might have more options for positive behavioral responses from which to choose when auditory over-stimulation would normally trigger acting out or negative behavior. In short, the music experiences were sensory awareness resources for interrupting neurologic noise set up by the environment. The results from this small study were mixed. Two of the three patients used the music based strategies and demonstrated reasonable success over the eight week program. One patient demonstrated no recognizable positive change in behaviors. The study, however, raised a number of interesting questions. Mostly it inspired thinking about what different approaches or techniques might be designed in order to practically expand music interventions to the entire unit.

The census of this unit, at any given time was 12-18 coed patients with a range of ages 3-12. The therapeutic music activities/experiences available to all patients, at that time, included two active music making groups and a small group or 1:1 music and imagery session. Most patients were available for the active music groups but not necessarily on a consistent basis. Particular children were selected for small group or individual sessions through clinician recommendation. "Lullaby Night" replaced the small group/individual time in the summer of 2000. This was an evening music time that was a passive music experience and all patients participated simply by being on the unit.

Initially the time frame for lullabies was from 19:00 to 20:30 PM. The music was performed using solo female voice and acoustic guitar accompaniment. The purpose was to provide calming but organized sounds on the unit to help the children settle more easily into bedtime. As the months went by, Tuesday became the established lullaby night. The time was moved to 18:30-20:00 since more activity occurred at 18:30 and the hope was that anxious behaviors might not escalate if the music started before such things as the end of visiting hours, snack and ADLs (activities of daily living). A review of the Aggressive Behavior Log from 1 March through 31 December 2001, provided insight that the 90 minutes of music on lullaby night indeed might have an impact on patient bedtime behavior and even affect the overall nighttime aggression levels. Data was examined for entries between the 18:30 and 06:30 hours. Log documentation showed 18 entries for Tuesday evenings

as low compared to a high of 51 on Fridays over the nine-month period. Seeing these figures was startling and the question was "Could it be the music?"

(insert charts c & d)

If the music was helpful in reducing the number of aggressive behaviors on Tuesdays maybe music would also be useful on other nights. Providing live music seven nights a week was not possible but recorded music was used regularly on the unit for a number of activities but not with the same intentions with which the lullaby night was designed. The next step then was to design an appropriate recorded music program for the same time frame (90 minutes) and the same placement (provided on both corridors) and collect the number of aggressive behaviors logged for the same twelve hours (18:30-06:30). This was the called the 90 minute Music Study. This use of music as a passive intervention for reducing milieu disruptions related to patient bedtime anxiety on the children's unit was run for a six week period. Data was also collected for 2 weeks pre and 2 weeks post project. The study was conducted from mid April through June of 2002. Three music styles were used as two-week interventions, all of them recorded on compact discs. Music styles were selected based on the types used most often on the unit for "quieting/calming" effect.

The first style was electronically generated "ambient" music. The second style was instrumental classical music. The third style was the same vocal music with guitar accompaniment used on the lullaby night but professionally recorded on to compact disc for use in the study. A maximum of five battery-supplied boomboxes were strategically placed in corridors and monitored for consistency in broadcasting. The six weeks of the recorded music intervention was designed to use the 18:30-20:00 time frame for six nights and Tuesday remained the "traditional live music lullaby night. The following information was provided at the end of the 10 weeks:

(insert charts e & f side by side)

Sound Environment Responses

The impact of the three interventions on patient behavior was not found to be statistically significant, however, the music used in intervention number two appears to have had a positive effect. What again appeared obvious was that classical recorded music had some beneficial impact on decreasing patient anxiety and aggressive behavior around bedtime activity. Short clips of each style of recorded music were then examined and a great discrepancy in frequency wave shapes was obvious.

(insert charts g, h, i)

The Aggressive Behavior Log documented that behaviors were more or less aggressive during the various styles of music. Looking at the wave shapes of these styles might provide a sense of why documented behaviors were so different. Describing the three music styles via wave shapes and suggesting how documented behavioral responses might be explained was important. The synthesis of both pieces provided four considerations: (1) the type of rhythmicity, found within the melodic and harmonic structure of classical music, provided an entrainment and an unconscious sense of predictability; (2) nature sounds, or electronic unmetered music could not provide the necessary sense of beat for the entrainment useful to feed and calm an anxious auditory system; (3) scanning for low frequencies is a significant responsibility of the dorsal component of the vagal system for survival, thus, in the most alert of states, auditory filtering goes on for survival's sake; and (4) The frequency organization of the classical music selected for the study may have absorbed intrusive low-frequencies of the ambient environment, in a sense transforming them.

Challenges to providing sound transformations

Fundamental to the delivery of recorded music in this study were both the design and construction of the unit and the music delivery system itself. The construction of any public or commercial structure obviously has specific limitations especially in terms of materials used in its construction, due to codes and regulations dictated by the purpose of the facility although the actual configuration might be negotiable. The design of this particular unit was a sort of double "L" shape with one short and one long corridor (all carpeted) on to which patient double rooms open. The routing of sound down both corridors and into rooms was one challenge. There was also the fact that not all patients sleep in their assigned rooms, especially when they are new admissions who must sleep within staff sight. Such patients then are bedded in either of two spaces near the nurses' station in rooms designated for dining and

lounging spaces. Sound delivery then becomes more challenging, given the sound of electrical appliances such as refrigerators, fans and clocks or proximity to phones and overhead speakers.

Five boomboxes were chosen for the sound delivery with three being the same brand and style for the corridors (2 on the long and one on the short) and the other two boxes reserved for the dining and lounge areas. No power cords could be used for operation so all devices were battery powered. Since fire codes require that corridors remain obstacle free at all times, there are no shelves on which to place objects of any sort, therefore, the boomboxes were placed on the floor in the corridors and on shelf space in the dining and parlor areas. An additional piece of design that challenged sound routing was a crown section at the start of the long corridor. The difference in ceiling materials and in the increased height created a type of "capture" space for sound.

(insert chart j)

The greatest challenge in music delivery, however, was due to the styles of music. The electronically generated "ambient/new age" recording had no pulse and could be started even at random without sounding "out-of-sync". The classical recording demonstrated that even though with a synchronized start, the speed at which each boombox played was just enough different that after three to four minutes of music, each one was out of phase with the others. But because the classical music was instrumental/orchestral with varying frequencies and implied pulse, careful monitoring of volume limited the impact of the phasing problem to a great degree. The recorded "lullaby" disc provided the greatest dilemma related to phasing. Having a highly defined pulse from the guitar accompaniment and the vocals being word based, the issue of "out-of sync" was huge. Constant monitoring of volume and cutting back to one boombox on each corridor helped only minimally. Words/lyrics travel easier in terms of consciousness and if those words are not together the sound can be irritating. So there were routing issues due to unit design and the material of the built environment, and the sound delivery system added its own dilemmas. It isn't surprising then, that no significant differences were found among the treatments, except that the classical music still appeared to provide some positive effect.

Keeping in mind that the Tuesday's lullabies remained a constant but were "live" versus recorded music, the Tuesday data was also collected but not figured into the six nights a week when recordings were used. Examination of this data showed that across the three interventions produced the same number of documented incidents as the classical music two-week intervention. So another question popped up, "What else is at work?" Often the simple or obvious answers are the most profound.

The answer seemed to be "Because of particular differences between live and recorded music. More precisely: live music has an impact upon the ear different than recorded music by the sheer fact that the environment both acoustically and interactionally are "in process". In addition, frequencies and decibels are in that process "in time" – one element that recorded music freezes then replays "out of time". Therefore, the interaction between performer and audience is organic and dependent upon the: (1) sound dissemination system; (2) acoustics of the environments; (3) auditory perceptions; and (4) "in-the-moment" responses.

Sound Hospital Responses

Returning, once again to comments from Mazer's work: "To be a state-of-the-art-hospital, the auditory environment must exemplify the highest and most compassionate standards of patient care. Setting sound standards for equipment, technology, and design makes it possible for a patient to move through the healthcare system, from department to department, and experience the same standards of care. Aim for more than auditory neutrality of the myth of "do no harm" when it comes to noise and distraction by providing music and nature, fountains, or other pleasant sound sources that can improve the quality of the healthcare experience. Go back to your own hospital and listen. What you hear should reflect the same values and standards as the clinical care you provide."

The seeming positive effect of live vocal with accompaniment and recorded classical music provided enough curiosity to consider further investigations. The next study was designed to examine the impact of live classical instrumental music and live vocal music on the bedtime milieu behaviors. It was completed in March of 2003. This also provided exciting information and the most recent study was designed to examine the impact of recorded classical music on targeted nights. It was completed May of 2004. The results of both studies are to be published at a later date.

Over stimulation of the human auditory system can negatively impact treatment in health care settings. For most people, the effect of auditory stimulation is an unconscious experience. The auditory system is the only sensory system over which the individual has no control. It is the auditory system, however, that is most assaulted yet may have the greatest capacity to mediate and repair much damage to both behavior and physiology. As awareness becomes conscious related to the impact of both general and particular auditory stimulation on behavior, such sounds may then

become a significant consideration in the design of facilities offering health related activities as well as a tool for treatment.

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CHAPTER 62

*Dialogues about music
therapy research*

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A number of changes in the status and ways of viewing music therapy research have taken place in the last decade. In this presentation, they were shared from the perspective of the editor of *Music Therapy Research: Quantitative and Qualitative Perspectives* (1995). In this presentation, the editor's views of changes in the status of music therapy research and their relationship to the plans for a revised edition the book, which will be titled *Music Therapy Research*, 2nd Edition, were presented. In addition to the editor/presenter's perspectives, dialogues between and with some of the contributors to the book were shared.

Ten years ago, there was only one book specifically on music therapy research, *Experimental Research in Music* by Clifford Madsen and Charles Madsen (1970). In the intervening 10 years, a number of books appeared on this subject, including

the following: Music Therapy Research and Practice in Medicine by David Aldridge (1996);

Beginning Research in the Arts Therapies by Gary Ansdell and Mercedes Pavlicic (2001); Qualitative Music Therapy Research: Beginning Dialogues by Mechtild Langenberg, Kenneth Aigen, and Jörg Frommer (1996); Multiple Perspectives: A Guide to Qualitative Research in Music Therapy by Henk Smeijsters (1997); and

Music Therapy Research: Quantitative and Qualitative Perspectives, edited by Barbara Wheeler (1995).

Need for New Edition

The need for a new edition was perceived as being due to the following:

- Increases in literature, updated references
- More international
- Clarify relationship of research methods to ontological and epistemological stances
- Quantitative-qualitative clarification and discussion
- Define and clarify qualitative methods
- Questions about philosophical inquiry and theory development
- Clarify some issues in quantitative methods
- More complexity in “other” approaches
- Case studies—qualitative and quantitative
- Computer applications

More information on some of these needs is shared below:

International Focus

The first edition included only U.S. authors, while the second edition includes 13 international authors. The authors of the second edition, and their countries, are included in Figure 1.

FIGURE 1. Music Therapy Research, Edition 2

Barbara L. Wheeler, Editor

I. MUSIC THERAPY RESEARCH: OVERVIEW AND ISSUES

- 1. Introduction: Overview of Music Therapy Research** - *Barbara L. Wheeler*
- 2. A History of Music Therapy Research** - *Jane Edwards*
- 3. Philosophy and Theories of Science** - *Even Ruud*
- 4. Principles of Quantitative Research** - *Carol Prickett*
- 5. Principles of Qualitative Research** - *Barbara L. Wheeler & Carolyn Kenny*
- 6. Funding Music Therapy Research** - *Jane Edwards & Debra Burns*

II. THE RESEARCH PROCESS

- 7. Topics and Questions for Music Therapy Research** - *Kenneth E. Bruscia*
- 8. Developing a Topic** - *Barbara L. Wheeler*
- 9. Reviewing the Literature** - *Cheryl Dileo*
- 10. Designing a Quantitative Study** - *Barbara L. Wheeler*
- 11. Designing a Qualitative Study** - *Kenneth E. Bruscia*
- 12. Data Analysis in Quantitative Research – Statistical Methods** - *Tony Decuir*
- 13. Computer Programs for Quantitative Data Analysis** - *Tony Meadows*

14. Data Analysis in Qualitative Research - *Kenneth E. Bruscia*

15. Computer Programs for Qualitative Data Analysis - *Jim Musumeci, Joseph Fidelibus, & Suzanne Nowikas-Sorel*

16. Writing the Quantitative Research Report - *Michael G. McGuire*

17. Writing the Qualitative Research Report - *Kenneth Aigen*

18. Ethical Precautions - *Cheryl Dileo*

19. Evaluating Quantitative Music Therapy Research - *Cathy McKinney*

20. Evaluating Qualitative Music Therapy Research - *Brian Abrams*

III. TYPES OF QUANTITATIVE RESEARCH

21. Experimental Research - *Suzanne B. Hanser & Barbara L. Wheeler*

22. Survey Research - *Tony Wigram*

23. Meta Analysis - *Cheryl Dileo & Joke Bradt*

24. Single Subject Designs - Quantitative Case Studies - *Henk Smeijsters*

25. Single Subject Designs - Applied Behavior Analysis - *Suzanne B. Hanser*

IV. TYPES OF QUALITATIVE RESEARCH

26. Phenomenological Inquiry - *Michele Forinash & Denise Grocke*

27. Hermeneutic Inquiry - *Mechtild Jahn-Langenberg & Joanne Loewy*

28. Naturalistic Research - *Kenneth Aigen*

29. Grounded Theory - *Dorit Amir*

30. Heuristic Inquiry - *Kenneth E. Bruscia*

31. Ethnographic Research - *Brynjulf Stige*

32. **Participatory Action Research** - *Brynjulf Stige*
33. **Narrative Inquiry** - *Carolyn Kenny*
34. **Morphological Research** - *Eckhard Weymann & Rosemarie Tüpker*
35. **Qualitative Case Studies** – *Henk Smeijsters & Trygve Aasgaard*
36. **Arts Based Research** - *Diane Austin & Michele Forinash*
37. **Personal Construct Analysis** - *Brian Abrams & Tony Meadows*
- V.MUSICAL, PHILOSOPHICAL, THEORETICAL, & HISTORICAL RESEARCH
38. **Approaches to Researching Music** - *Lars Ole Bonde*
39. **Philosophical Inquiry** - *Kenneth Aigen*
40. **Developing Theory** - *Kenneth E. Bruscia*
41. **Historical Research** - *Alan L. Solomon*

Research Interests, Methods, and Epistemologies

It is expected that the new edition will help readers to understand the importance of coherence among interests, methods, and epistemologies. There is ongoing discussion of this in many chapters of the book. In addition, the new edition includes a chapter on Philosophy and Theories of Science which addresses these issues.

QUANTITATIVE – QUALITATIVE ISSUES

There are various attitudes¹ toward this issue:

1. These labels, except for mixed methods, are from Bruscia (personal communication, 2003, revised 2004). Some of this information was revised after the presentation in Finland.

- Radical quantitative – People holding this view use only quantitative methods and believe that only these methods produce useful information.
- Assimilative quantitative – People holding this view do quantitative research but supplement it with qualitative information. A typical study using this approach might use information acquired by interviewing people after a quantitative study to help to understand why they responded as they did. The presenter suggested that these researchers use qualitative data but that this would not qualify as a qualitative study.
- Equal acceptance – mixed methods designs – Mixed methods designs attempt to utilize both quantitative and qualitative methods, and are a popular approach at this time. Equal acceptance can also mean that the two paradigms are not mixed in the same study (a stance that Bruscia took some time ago). Thus, equal acceptance must also include the use of quantitative research for those questions requiring positivistic answers and the use of qualitative research for those requiring nonpositivistic answers.
- Radical qualitative – People holding a radical qualitative view believe that only qualitative methods are suitable for doing music therapy research, and reject any use of quantitative methods.
- Assimilative qualitative – People holding this view do qualitative research supplemented or informed by quantitative information. An example is the Rep-Grid technique.

DEFINE AND CLARIFY QUALITATIVE METHODS

The first edition of the book included only two types of qualitative methods, with the following chapters:

- Interpretational Research
- Phenomenological Inquiry

The second edition includes the following chapters on qualitative methods, clearly offering much more coverage of these methods:

- Phenomenological Research
- Hermeneutic Inquiry
- Naturalistic Research
- Grounded Theory
- First-Person Research
- Ethnographic Research

- Participatory Action Research
- Narrative Inquiry
- Morphological Research
- Qualitative Case Studies
- Arts Based Research
- Personal Construct Analysis

CLARIFY ISSUES IN QUANTITATIVE METHODS

The quantitative section of the first edition of the book was organized as follows:

- Experimental Research
- Descriptive Research
- Survey Research
- Ex Post Facto Research
- Case Studies
- Developmental Studies
- Applied Behavior Analysis

The second edition has the following organization:

- Experimental Research
- Survey Research
- Quantitative Case Studies
- Single Subject Design - Applied Behavior Analysis

The methods contained in the Descriptive Research chapter in the first book have been moved to other chapters in the second edition, with Survey Research, which is often done in music therapy, having its own chapter. Ex post facto research, which was included under Descriptive Research in the first book, will be covered under Experimental Research in the second edition. The second edition has a chapter devoted to Quantitative Case Studies, as well as the chapter on Single Subject Designs/Applied Behavior Analysis (which could be included with case studies). Longitudinal studies, a type of descriptive research, will be included in a portion of the Quantitative Research section, as this type of research could be very useful in music therapy even though there is little of it at this time.

COMPLEXITY IN “OTHER” APPROACHES

The first edition of the book included Philosophical Inquiry and Historical Research as other approaches. The second edition includes four in this section, reflecting additional thought and discrimination among some of these approaches to research. These chapters are Approaches to Researching Music, Philosophical Inquiry, Developing Theory, and Historical Research.

Case Studies

This edition includes description and examples of case studies in two categories, Qualitative Case Studies and Quantitative Case Studies.

DISTINCTIONS AND DISCUSSIONS

Four areas were considered under this topic: the discussion of qualitative and quantitative distinctions, which continues; research, theory, and practice is an area in which the distinctions are changing; a discussion of what is research and when something becomes research; and discussion of qualitative philosophies, methods, and techniques. These are considered in more detail below:

Qualitative – Quantitative Distinctions. This discussion is based on the different assumptions underlying positivist and nonpositivist approaches to research. Dialogues with Jane Edwards and Kenneth Bruscia, quoted below, were shared:

Jane Edwards, Sept. 15, 2002, wrote (in an e-mail to the presenter²):

I would suggest that positivist research is really not done in music therapy any more. It is the paradigm that requires all variables to be controlled in the method so cannot be conducted in a natural setting – since nearly all MT research is conducted in the natural setting I suggest it is post-positivist or constructivist in orien-

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2. In a follow-up e-mail, following the conference presentation, Jane Edwards has clarified and said: I mean that post-positivist means everything after positivism and true positivistic research can only use the laboratory (because in the natural setting even if our variables are as controlled as they can be there are confounders—in post-positivism the belief is that the natural setting generalises best to the natural setting and hence the natural setting is used rather than the lab). Because of this I believe that the current crop of quantitative research in music therapy is post-positivist and that because post-positivist means (simplistically) everything after positivism then constructivist approaches can also be described under a meta-category of post-positivism.

tation. Post-positivist uses the natural setting but if quantitative method then has a control and if qualitative method then usually has a quite structured method (like GT but sometimes case study fits here) and then constructivist research is where there is no possibility to use quantitative method because the ontology doesn't allow it – the belief is that reality is constructed and therefore truth is relative.

The Presenter's View

Although music therapy research may not be able to be controlled as completely as Jane feels it should be to be in the positivist paradigm, I think that it is still in that paradigm since it *strives* to be that controlled and the beliefs underlying it are the same. It makes more sense to me to place many qualitative methods in the postpositivist paradigm.

Ken Bruscia, April 10, 2003

I believe that in qualitative research (practice) there are many paradigms. In fact, that's the main problem with defining qualitative research or calling it anything else. Based on the Handbook of Qualitative Methods, qualitative paradigms include: postpositivism, constructivism, and critical theory. I myself am beginning to wonder whether there are even more, especially if you look at the practices. For examples: When you really get into ethnography, it qualifies as a paradigm – it has its own set of beliefs about the world and knowledge, along with very specific approaches to research; the same can be said for hermeneutics.... Maybe what I am saying is that a research paradigm can be broadly defined as a “way to knowing what is of interest.”

It is the presenter's view that qualitative and quantitative research are not in opposition but have different sets of assumptions. On question is, can you combine or does this weaken both types? A distinction can also be made between qualitative data, as is often used by people to supplement a quantitative study, and qualitative research, which involves beliefs and methodology unique to this type of research.

DISTINCTIONS AMONG RESEARCH, THEORY, AND PRACTICE

These seemed distinct in first edition but, particularly with participatory action research, the distinctions are now blurred.

Dialogue with Bruscia, April 9, 2003, in which he said:

“The distinctions between research, theory, and practice are arguable, and possibly irrelevant, because qualitative researchers are really blurring the boundaries.... Nowadays, any way to knowing can be considered research. Also, nearly every effort to do one is influenced by the other in varying degrees.”

WHAT IS RESEARCH? WHEN DOES SOMETHING BECOME RESEARCH?

This question comes up often in both quantitative and qualitative research. A dialogue with Carolyn Kenny, shared through her contribution of the chapter on Narrative Inquiry as part of the qualitative research section, included:

“Though much scholarly work is involved in the creation of categories, we must take some caution regarding the assumption that research must do an analysis and create categories to qualify as research.”

In quantitative research, people often collect data but this is not necessarily research.

Finally, as discussed earlier, people may collect qualitative data. This may be done when the researcher, as follow-up in a quantitative research study, interviews participants to find out their perceptions of the research. This would be qualitative data but not qualitative research.

QUALITATIVE PHILOSOPHIES, METHODS, TECHNIQUES

A number of distinctions and clarifications as applied to qualitative research come up in the process of working on this edition of the book, and will appear in the book itself. One area is exemplified in a discussion among Barbara Wheeler, Kenneth Aigen, and Kenneth Bruscia. The dialogue is summarized below:

Aigen wrote,

“Just about every single qualitative study in music therapy uses elements of different approaches and almost none of them follows one method exclusively.”

Bruscia wrote,

“There are three horrendous difficulties in understanding qualitative research: (1) the different views on epistemology and methodology with regard to the SAME type of research (e.g., hermeneutics), given by different disciplines (e.g., hermeneutics in history is different from hermeneutics in social work,” ...

(2) the overlaps of methodology (e.g., phenomenology and hermeneutics, ethnography and phenomenology). So part of the problem is that when you label your discussion, you can’t keep any boundaries on it... I start on phenomenology and end up on hermeneutics, which takes me to ethnography,” ...

(3) Sloppiness with language. People label their research incorrectly, or based on an inadequate understanding.”

The dialogue continues in music therapy research continues. These are important issues for music therapy researchers to sort out, and the dialogue is healthy. The presentation ended with an invitation to those in attendance (and others) to join it.

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CHAPTER 63

*Issues in measuring the effects of
music therapy with patients with
cardiac problems*

Wheeler, Barbara L.

**Symposium Title: Measurement
Strategies in Music Therapy Clinical
Practice for General Medical Settings**

This symposium presentation described a music therapy program for patients in cardiac units of a general medical facility. The questions addressed in this presentation follow:

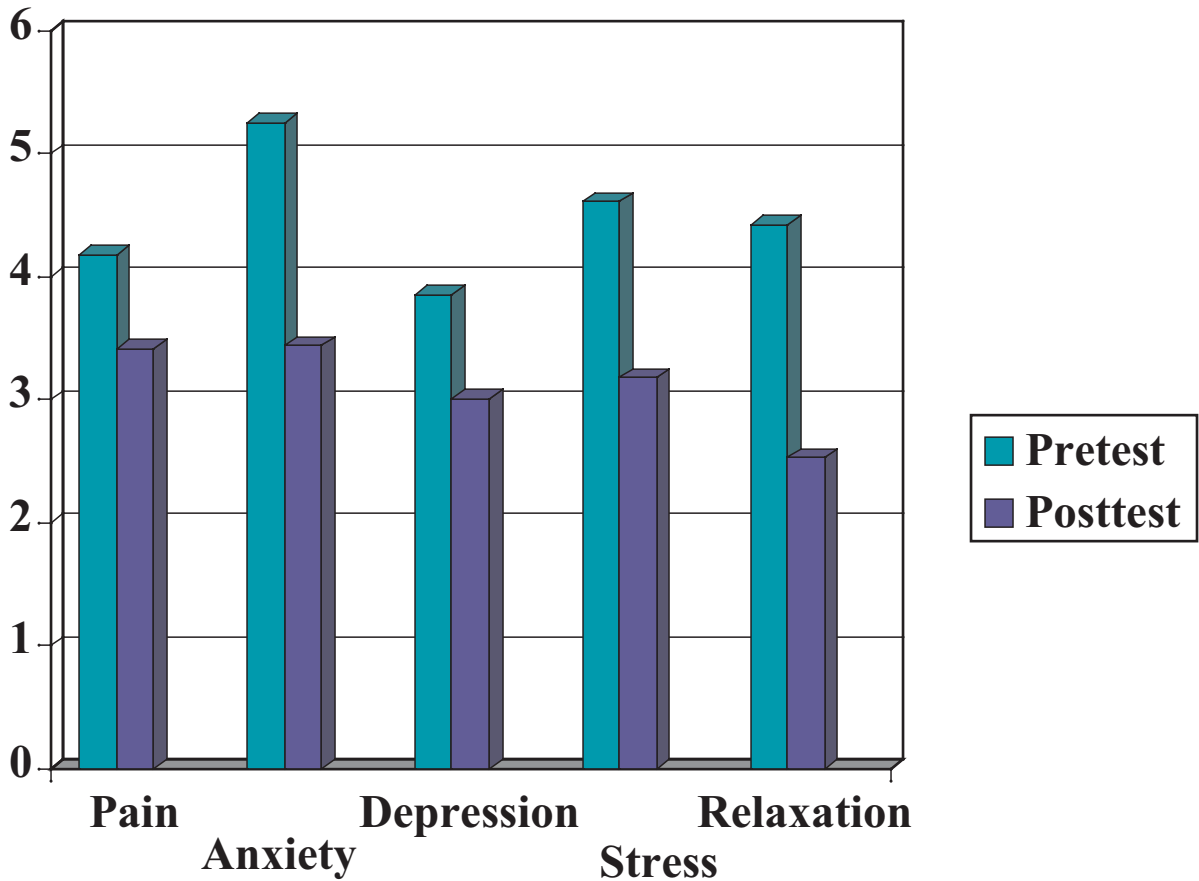
- What are the best means of measuring the effects of music therapy with cardiac patients?
- What are the problems with measurement?

The presenter's experience using these measurement techniques was primarily as part of a summer music therapy cardiac demonstration program. This was part of a 10-week project at a medical hospital in Louisville, Kentucky. The cardiac units offer three types of care: general cardiac care, surgery and follow-up, and short-term cardiac rehabilitation. Patients typically enter the hospital and are found to have a cardiac problem, then are sent to the general cardiac unit. Those who are found to need surgery go to the surgery and follow-up unit. They are generally on that unit for only a few days. Some are then transferred to the short-term cardiac rehabilitation unit where they stay for approximately a week. Others go back to the general cardiac unit and are typically discharged in about a week.

Although the presenter works part-time at this hospital on an ongoing basis, this 10-week project was set up to demonstrate the viability of music therapy in this setting in addition to offering music therapy services on a more intensive basis than is normally possible at this hospital. A music therapy student performed most of the music therapy, under the supervision of the presenter/music therapist, and worked at the hospital 5 days a week for the duration of the project. This was a clinical project, not formal research.

The measures that have been used in the demonstration program include a visual analog scale assessing pain, anxiety, depression, stress, and relaxation; and physiological measures of heart rate, blood pressure, and respiration rate. The results of the visual analog scale are shown in Figure 1.

FIGURE 1. Results of Visual Analogue Scale, Cardiac Demonstration Project



A review of literature of the results of physiological measures that have been utilized to measure the effects of music and music therapy in cardiac care shows contradictory findings. Some studies find systematic and often positive effects with music, others do not. Explanations for some of the contradictory findings may be lack of clarity in defining the variables including patient characteristics, or present-

ing accurate information about the music therapy is used, but in other cases, the variation in results seems to be random. In the demonstration program described, there appeared to be many influences other than music therapy on the measures, including mechanical devices controlling heart rate, medication, stimulation from the session and therapist contact. These measures were eventually dropped for this project.

Questions that arise from the experience with the demonstration program include the following:

- What were the differences in these physiological measures and others that *do* find systematic changes? Many studies in the literature find changes in heart rate, blood pressure, and respiration rate with music and music therapy, but many do not. Some music therapy studies find changes in heart rate when improvising (e.g., Neugebauer & Aldridge, 1998).
- What distinguishes studies that find physiological differences with music therapy from those that do not find these effects?
- How detailed must attention be to individual differences?
- What music is used and how specifically must it be detailed?

The following psychological measures that might be useful in measuring changes in cardiac rehabilitation were illustrated:

- Visual Analog Scale
- McGill Pain Questionnaire
- State-Trait Anxiety Scale – Spielberger
- Profile of Mood States (POMS)

Suggestions for further study include developing a better understanding of physiological measures, determining what psychological measures capture intent of music therapy treatment(s), and examining the relationship of physiological to psychological measures.

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CHAPTER 64

One must not pick the flowers of a garden'' - coping in the shadow of terror

Wiess, Chava

Over the past three and a half years I have been treating children who are victims of terrorist attacks and I am a part of a staff that have been conducting workshops dealing with stress and crisis through music . The workshops are geared for both adults and youth who live in high risk areas in Israel. Some of the workshops are for victims of terrorist attacks, and some of them are for their families and friends. In this capacity I have been frequently called in soon after an attack has occurred. The people's fears can be divided into two areas. One, they are afraid of being shot at while commuting to and from work, and two, they are afraid of terrorists invading their homes. The reactions to this anxiety can vary between locking doors and shutters during the day or just at dark, some don't travel at all at night and stopped working. Some send their children to live with other relatives. Younger children may start to wet the bed, have nightmares and may refuse to stay alone.

The ongoing anxiety and tension is a daily phenomenon and has lasted in Israel for the past three and a half years since the recent terror attacks started.

In the framework of this presentation I would like to focus on the people, their feelings, and the coping mechanisms of both people who live in high risk areas in general and terrorist victims in particular. I will describe the feelings and the strength

that these people gain through music, since music is a very important part of the workshop and helps people grapple with their emotions.

Up To this day about a thousand Israelis have been killed by terrorists. This number, in percentage of the population would be about ten thousand in most European states. This number reflects those killed in the past three and a half years. A large part of the victims are children, and many more children are left orphaned which one or both parents died as a result of a terrorist act. In the places that I work, 125 people have been killed, 50 of which are children and youth.

Workshop Procedure

The workshops take place in the workplace or in the places where people live. They last about five hours and occasionally they are divided into a number of sessions. There is an enormous amount of people that return to the workshops. During the workshops we concentrate on releasing tension, expressing and coping with feelings by listening to Israeli songs, playing musical instruments and songwriting. In this presentation I will focus only on the use of Israeli songs.

ISRAELI SONGS

Israeli songs take a central role in Israel. Communal singing in public is an important and meaningful part of Israeli culture. It raises the national morale and it helps people support each other in difficult times. Singing in public is acceptable in almost all parts of Israeli society and it helps to unify and to soothe everyone. The history of Israel unfolds through the songs, including the meaningful events and the difficult times. During the past few years there has been a strengthening of this phenomenon due to everyone's need for a boost to their morale and a feeling of belonging. That is why I decided to work with Israeli songs in my workshops.

HOW THIS TAKES PLACE

The songs are selected according to the age and type of population, for example the youth, choose songs from the last decade, or adults will choose older songs. Every member gets a booklet with 50 songs. The group members are invited to choose a song that expresses their ways of coping with a crisis situation. In reality, what happens is that they select songs that express their feelings that arise from the situation. There are those who select songs which express their ways of coping with personal crisis. We perform every selected song with my accompaniment by the guitar, and everyone singing together. The one who chose the song recites the sentences which

focus his emotions and then we have a discussion among the group members about this person's way of coping with the situation. My role as a group leader is to act as a mirror and to reflect their pain and their strengths. Their song selections seems to be very significant in that it signifies everything that bothers that person. My feeling is that the guitar accompaniment is of great assistance in helping the group members to connect. We are all aware of the difficult times in which we are living but we are not totally aware of the feelings that these times engender. Israeli songs opened a window to me into man's soul and gave me a chance to penetrate to the world of pain, hope, desperation and love. The songs assisted me in coping with fears and anxieties, loss and pain. If it weren't for the songs' some topics would not have even emerged verbally. My guess is that a song can contain everything – threatening emotions and thoughts that would not emerge otherwise and subjects which are taboo.

THE IMPORTANCE OF PERFORMING A SONG

Performing a song in a group carries a lot of emotional value. In the literature of music therapy singing songs is an immediate and positive emotional experience. Combining emotional, verbal, social, spiritual, communicative, physical and cognitive aspects. This experience usually arouses senses of enjoyment, encouragement, belonging, and insight, identifying with the other, cooperation and release from emotional and mental tension. Eliram, who specializes in Israeli songs claims that singing enhances an uplifting of the soul into another sphere. She points out that singing in public is an experience which enhances togetherness and belonging. This takes place under the impact of the musical and extra-musical components. When people sing together it is like a person getting in touch with himself. The combination of all of these elements enhances the power of the songs and entails and triggers a direct and immediate reaction of the people who take part in the workshop. The reaction can be physiological such as weeping or laughing and the urge to hug as well as an emotional attachment.

I want to start with the first example. The songs are translated into English, but you will hear the original songs in Hebrew. In most of the examples I will bring only part of the song.

The following song is called “place for Concern” . It was written during the late 70s. It is written in a minor key and is in a melancholy tone. the song speaks about a remote and neglected place that even god is worried about .

FIGURE 1. (1st recording+slide)



THE BEAUTY IN EACH SONG

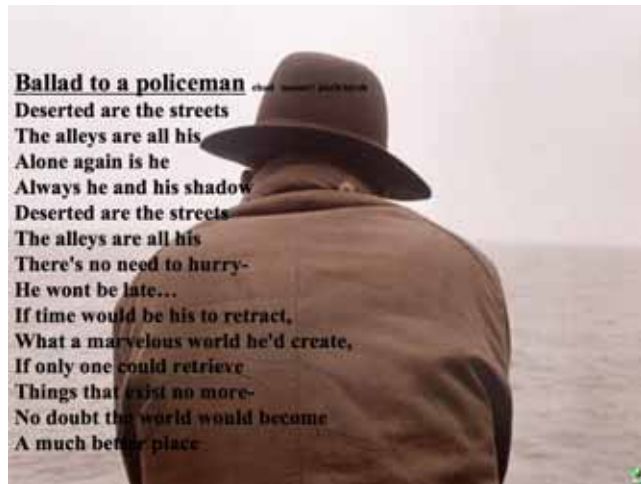
The beauty in the song “Place for concern” is that different people can see different things in the same song, and they can connect to different ideas and feelings. Each person can identify with the verbal or musical content which brings up things from their inner world. We have seen that Yael refused to accept the fact that her flower was picked. Rina, a second generation member of a settlement, chose different words from the same song. “There’s a far-away place, A tiny, miserable, crazy place, A place of big concern”. Rina said: “I feel unwanted because of the place where I live. My home is treated like a remote and a neglected place because of what is happening. It is not as simple as they think to leave the house where I have lived all of my life. I feel unwanted and hurt.” Besides the pain Rina feels rejected. Shelley was calmed by the very same song. She chose a different sentence, the one that talks about G-d sitting there and guarding everything that he created and is terribly worried. Shelley found solace in the sentence “God is worried.” Tova, on the other hand was bothered by the song. It emphasized her deep worry and concern and feeling of helplessness. She is worried about her children and friends and the entire situation in Israel. One can see that the feelings and emotions which emerged from the song varied from pain to anger, sadness to hope and finally to worry and concern. Each one of the participants connected to a certain sentence through the experiences and emotions which emerged from her own personality. The group provided different outlets for the participants. There were those who were supported by the group which gave them the strength to continue. There were

others to whom the group provided a place to weep and still others who could raise the questions that they were bothered by. There were those who just needed a place where they could ventilate everything that bothered them.

I will bring some examples where we'll see in some songs people who express their pain and in others find strength

David chose the song “A ballad to a policeman”

FIGURE 2. (2nd slide).



The song was written in the seventies. It is a song which speaks about loneliness. The song is melancholic and played in a minor key (2nd song). The whole group sang together and David chose the following sentences from the song. “Deserted are the streets, the alleys are all his, alone again, is he, he and his shadow.” David looked at the group and said: “In the place where I live all the neighbors around me have left because of numerous terrorist attacks. My wife and I are the only ones remained on the street and I feel lonely. I wish I could turn the clock back.” The entire group started to cry in empathy. Towards the end of the workshop David asked to sing “The song of love”

FIGURE 3. (3rd slide).



This is a new song which was written 4 years ago. It has a mixed style with an ethnic tone that comes from several places in the world. This style has become very popular in recent years. The song is sung in a major key and its rhythm is lively. It speaks about the power of togetherness (3rd song). David said that the power of togetherness is what gives him the energy to go on in spite of everything. He took a Darbooka and started drumming while the rest of the group started dancing and hugging each other. David found in the songs a way to express his pain and in another song he found strength.

In another workshop, Shosh whose best friend Roni lost her husband during the same month, chose a song called “All the stars”.

FIGURE 4.



This song was written 3 years ago. The song deals with the attraction that a man has for a woman and his inability to make their relationship real which leads to feelings of pain and powerlessness. The song is played in a minor key and has a large range (4th song). She chose a refrain which described how she felt. When she recited the refrain, her body language was very drawn in and bent over. With a quiet and slow voice full of pain, she recited "all the stars are falling, the brave men are departing. Whoever shouted is silent, whoever laughed is crying." Then she said, "I feel that only by my expressing and touching my pain then I could rebuild myself." Roni, who had lost her husband just a few weeks previously, was sitting close to her. She couldn't bear the pain and she started crying. Shosh talked about herself but also transmitted to Roni the message that she couldn't bear the pain. Until this day, a year and a half later, Roni is still unable to touch and connect to her pain. This affects her functioning at all levels, especially at home. During the same workshop it was very hard for the group to deal with what was happening and they asked to sing the song Amen.

FIGURE 5. (5th slide)



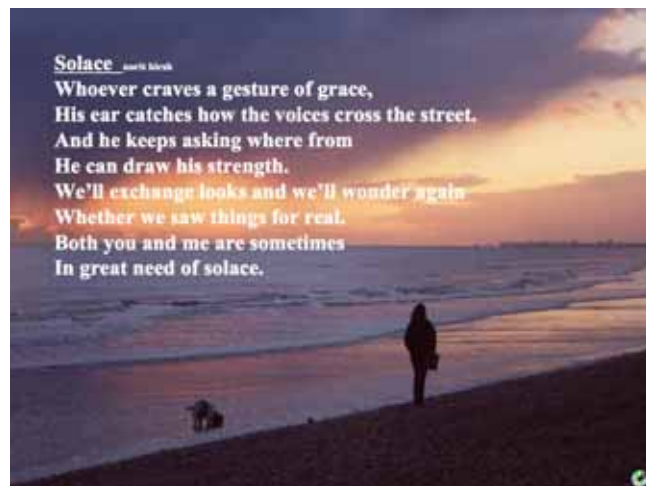
This song was written during the nineties in a major key, and has a wide range. The song is like a prayer to G-d asking for strength and protection (5th song). Almost all the member of the group started crying while singing. After they finished singing they expressed the will and the need to strengthen themselves by the following words of the song “strengthen our spirit, give us life and protect us, fulfill our love”.

In these examples, and there were many like this, one can see that the pain can be tapped and a dialogue can be created, where there is a personal interaction between the people and the songs. There is an expression of pain in one song and the need to strengthen in another. In many additional cases the participants “dedicated” songs one to the other in order to encourage and help each other. Occasionally I saw people who didn’t know how to react when someone burst out crying, but they found the way to encourage him by “giving” a song to the person who was crying, which to my mind was like giving a hug.

There is an interesting process here. At the start of all of the terrorist activity you could see that those who lived in high risk areas, where there were a lot of terror incidents and a lot of injuries and loses, people chose songs which spoke about strength, faith, and courage. There was no readiness to deal with pain. My guess was that the fear of dealing with the pain derived from another fear that if they did deal with pain something would collapse internally and their belief would crumble.

Today the need to deal with pain is legitimate. Also, asking questions and being confused is acceptable, which was not the case in at the start of events. A dialogue that would not be accepted, and emotions that people would be ashamed to bring up can be dealt with through the songs. The barriers come down and the most difficult feelings are tolerated which would otherwise not be accepted. At the same time there is a great mutual support. For example Noam told the group that she chose the song “Solace” which was written in the seventies.

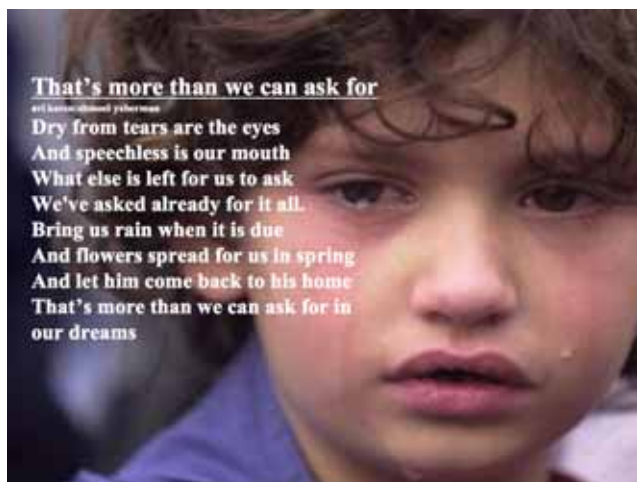
FIGURE 6. (6th slide).



Composed in a minor key it deals with the need for strength, solace and mercy (6th song). She chose the following sentence from the song: “keeps asking where from, he can draw his strength?” Noam added that sometimes she is ashamed to admit that she has no more strength and she can’t go on: “Everybody expects me to be strong and clear about my beliefs but I have doubts”. She added: “I have always believed in my way of life. I still believe, but now I let myself have questions and doubts.” There was an embarrassed silence in the group, but no one dared to criticize her.

In another workshop Ayala, who had lost her brother-in-law and her two nephews in a terrorist act, chose the song “that’s more than we can ask for” .

FIGURE 7. (7th slide).



In this song there is a plea for the trivial things of life and the pain when they are not given. The song is sung in a minor key (7th song). Ayala considered this song a protest against G-d. "My eyes have no more tears". You have already hit us, after we had already pleaded and prayed. What have we asked for? Only for rain, flowers in the spring, that each of us come home safely? We haven't asked for anything special! But even these things are not granted to us. The subject of anger towards G-d came up in this song and was followed by a discussion about whether there is room for this type of anger. This topic has been coming up lately and is considered legitimate even in the religious community.

Ways of coping

The importance of working in a group is that there are many different ways of coping, and even those who find it very hard and refuse to cope are affected positively by how others think and share their optimism. I will show a few examples of different ways of coping.

Miriam selected the song "Become my friend, become my brother".

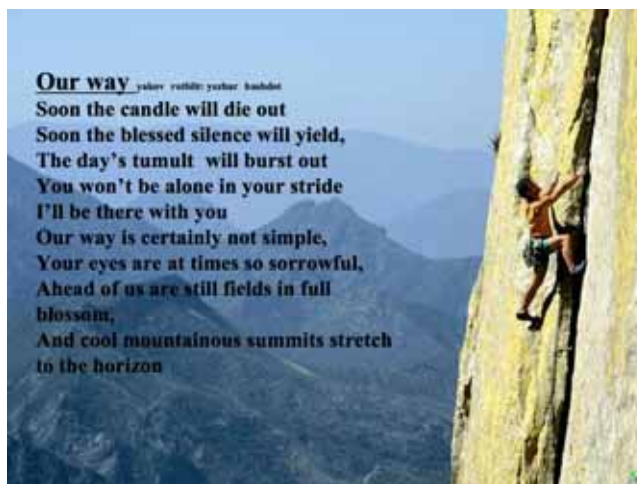
FIGURE 8. (8th slide)



This song was written in the sixties and it expresses the desire for a friend and the quest for help from that friend (8th song). Miriam chose “give me your hand when I call you”. Miriam said that during a crisis she needs a friend by her side. David, as we saw, chose the song, “song for love”. Togetherness assists David, and many others to overcome, to be encouraged, and to be supported. There were people who chose songs which speak about the family as their supporter. There were others who chose songs that speak about faith and prayer that help them to cope. Some chose songs that talked about smiles that help them to cope.

At the start of the terrorist attacks people refrained from bringing up their personal problems. Recently, every time I hand out the song booklets the personal problems come up with all of their accompanying feelings. It could be that continuing stress and tension sharpens their personal problems. The last example is of Ayelet who selected the song “Our way” .

FIGURE 9. (9th slide)



The song was originally written during the eighties and rewritten in 2001. It is in a minor key and was written by the poet to his wife who was severely ill. Through the song he wants to tell her that he is with her all the way. The song became popular in Israel especially because of the phrase: “our way is not easy.” While singing the song Ayelet burst out into heartbreaking tears.(9th song) At the end of the song Ayelet could hardly read the line: “you won’t be alone I’ll be with you”. She said: My husband and I have gone through a very hard time. My baby daughter was critically ill and after a while she passed away. My husband told me the following words which were very meaningful for me: “You are not alone, I will not leave you alone, I will always be on your side.” While she was crying Ayelet told the group that only her husband encourages her. The group members had not seen Ayelet before this workshop and they didn’t feel that they were able to get up and hug her. That is why they hugged her through the songs which supported and strengthened her and were more meaningful than a physical hug.

As I have noted already one of my roles in the workshops is to mirror people’s strengths. Many of the participants were unaware of their power. The songs that they chose gave me the proof and also the way to mirror their strength. Some of them stopped during the process and said: “Wow, I never noticed this, but now that you mention it I can see that it is true”. This mirroring gave them a lot of motivation and the power to continue.

Changes that I saw through the song from the outset of the events until the present:

1. I have realized while treating terror victims and by the reports of the workshop participants that due to the following loss and stress involved, their problems have become more extreme. For example one who was typically tense became even more tense to the point of a total inability to function. Introverted people became even more Introverted. Optimistic people became more empowered.
2. People who live in high risk areas that are under a lot of tension have had their personal problems come out into the open due to the continues stress and tension.
3. concerning the ability to deal with pain I noticed that there is a difference between those who are religious or traditional in their beliefs and those who are not religious in their ability and will to deal with their pain. People who were not religious were more willing to deal with their pain. From the very start of the period of terrorist acts, religious people did not deal with their pain for a very long time. This could derive from their anxiety and fear of diminishing their stamina. Dealing with pain became possible only after recurrent tragedies, and also from the insight that dealing with their pain did not mean that their beliefs would be damaged. My guess from the beginning was that if they expressed despair or fell apart then they would be saying that they have lost their way. But when they started to deal with their pain they realized that this was a healthy situation and that dealing with pain empowers, supports and encourages them.
4. The mode of coping by many of the religious people was expressed through their beliefs, through prayer and the spirit and also derived from the very strong need for togetherness and socialization.
5. The mode of coping by the non-religious was expressed by demonstrating patriotism, love of country and their friends. The non-religious participants, from the very start, doubted that the place where they lived was really their place.
6. Among the religious participants, at the beginning there was no room or legitimacy for doubts whether it's the right place to live. but after a few months those doubts started to emerge.
7. The farther into the high risk area that people lived and the more injuries sustained there, the harder it was for people to deal with the pain, and they expressed stronger beliefs that their way was right. As I have noted, though, in the last few months this has changed as well.
8. Youth and children experience post-traumatic symptoms, contrary to expectations on quiet days. The fears and anxieties emerge and physiological phenomena occur such as bedwetting, dysfunction in studies and aggressive behavior.

In summary, the songs gave people a communication channel to express what was in their hearts. The hardships, pain and even taboo subjects were reflected and brought people to insights. The songs contained everything and threatened no-one. They supported, empowered and encouraged. Each one found a song that touched his heart and felt that it was written for him only. My feeling is that if it weren't for the songs, all of the subjects that I have brought up in this presentation would not have come to the surface and would not have gotten their appropriate place.

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CHAPTER 65

*The artistic creativity of stressed and
traumatised people - A music
therapeutic interpretation of the tale
“The Bremen Town Musicians” in a*

*joint Polish-German
perspective*

Szulc, Wita& Wolfram, Ilse

Introduction

We came to the common work after having met last year in the EMTC meeting. Dr. Wita Szulc, Professor of Wrocław University (Poland), also Head of General Education Department, and President of The Polish Association of Arts Therapists “Kajros” and having published many articles, knows a lot about Art Therapy. As to myself, I do know more about Music Therapy in theory and in practice, as I am an active music therapist since 20 years and do teach and practice it. In the course of the EMTC meeting, we found how important it is also to learn more upon the working conditions of us professionals within Europe and that this knowledge could lead to connecting, networking, teamworking.

Furthermore, we both share the belief in the importance of a growing Europe. Wita made it possible to come to Bremen one day after the entry of Poland into Europe on 1st of May 2004, and lived with me through the celebration in the city house. There exists a special political and scientific relation between Poland and Bremen. The reconciliation following the sad events of Second World War has proved successful on many levels.

Our topic touches a few reference theories, such as:

- Artistic creativity
- Trauma theory
- Literature, i.e. science of Folk Tales

to which we will therefore refer in an appropriate and adequate way.

THE CONNECTING IDEA

We do not work with the same target group, but we both are convinced from the anthropological principle of the creative potential within human beings, and therefore have chosen the tale “The Bremen Town Musicians” as a connecting idea, because it is:

- a musical tale
- because it can be interpreted as a music therapeutic tale, what we will explain
- thirdly because it is an internationally - in variations - well known tale

FIGURE 1. Animals in Exile

Tales of similar content from all over the world - some examples

- The Bremen Town Musicians (Germany)
- The Choristers of St. Gudule (Flanders)
- The Robbers and the Farm Animals (Switzerland)
- The Story of the White Pet (Scotland)
- The Bull, the Tup, the Cock, and the Steg (England)
- Jack and His Comrades (Ireland)
- How Jack Went to Seek His Fortune, version 1 (USA)
- How Jack Went to Seek His Fortune, version 2 (USA)
- The Dog, the Cat, the Ass, and the Cock (USA)

Source: Internet

www.abney.homestead.com

- because we both like tales and use them in the therapeutic implementation
- and lastly, because I, being from Bremen, have a very direct connection with this tale, whose symbols can be found all over in Bremen and are being used for many purposes. To the citizens of Bremen, they transfer the meaning of freedom, success and security.

We have drawn from the tale a number of analogies to our professional psychotherapeutic field with stressed and traumatised people.

Of course, we do not intend to exclude other analogies or interpretations, which have already been done or will be made. It is certainly thinkable to imagine the four animals, the later Town musicians, as a team of old age beings. Or to conclude from the tale the necessity to demand the changing of the political structures in those countries where the refugees that I work with come from. Or the actions of the four town musicians can be applied to the viewpoint of jobless people, or for pedagogic purposes, or the protection of animals. And so on and so forth. We realized that it is a tale with an enormous power!

The tale

The Brothers Grimm are well known to many of you as collectors from folk tales. They spent their lifetime searching for tales and stories, and first published this one in the second edition of their book “Kinder- und Hausmärchen” in 1819. Since then, this tale has remained essentially unaltered in the following editions.

Tales have a lot of common features, which helps to understand their philosophical dimension.

FIGURE 2. typical tales features

1. PLOT FEATURES THREE PARTS

- The start situation

- a. lack, deficit= someone needs something

- b: evil acts= someone commits something bad

- The way of the hero or heroes

- a: test or probe= he or they must master a dangerous situation

- b: help or advise= from someone or something comes help, or counselling

- c: magic= the hero is empowered with a magic gift or charming object

- The solution, the answer

- a: salvation= of the hero or from another person

- b: marriage= typical for east-european tales

- c: coronation= typical in most countries

- d: punishment of the bad person(s) = reward for the good ones; the bad beings have to be punished

2. PERSONS AND COUNTRIES

mostly anonymous and of one-dimensional (how did the clever Jack really look like), the forest (which forest?)

3. SYMBOLISM OF NUMBERS

a: 2 for polarities = good and evil, life and death

b: 3 for the roundness, or endings = twice there is bad luck, but the third time there is achievement

c: 7 for positive strength = the seven dwarfs

d: 12 = reflects perhaps a religious connection

4. REPETITIONS

very common. As the plot is often very simple, actions are told repeatedly and often with the same words:

“Once upon a time”

.....and now to the tale itself, which I cannot recite you completely for lack of time, but in its essential parts.

... Once upon a time....Four animals, who have not known each other before, are the heroes. A donkey, a dog, a cat and a rooster. They have lived together with their masters, and have taken their good share in the hard work in the farms: the donkey carrying sacks to the mill, the dog hunting the hares, the cat hunting the mice, and the rooster prophesising the wheather and holding the herd of hens together. They become old and less and less useless, and therefore they shall be killed. First the donkey notices that it was not a good wind that was blowing and ran away, setting forth on the road to Bremen, where he thought he could become a town musician. On his way, he meets a dog having also run away, and invites him to beat the drums; he himself will play the lute. Then, later, both of them meet the cat making a face like three days of rainy weather for danger of being drowned, and the donkey reacts: after all, you understand music, come with us to Bremen to become a town musician. Later again, the three refugees meet the rooster crying with all his might, because he will have his throat cut the next day, and there is again the remark from the donkey about music:

After all you have a good voice. Something better than death we'll find always.
And when we will make music together, it will be something of a special kind.

So the four go off together, but have to stop in a forest, because Bremen is not be reached in one day. The rooster settles on the top of a huge tree and sees a little spark of light not too far away. Hungry and thirsty, as they are, they set forth again and reach a brightly lit robbers house. They discuss what they can do because all the food and warm atmosphere inside attracts them. They make a plan, to stand each on the back of the other and then make their music all together. They do this, and then crash into the house through the windows, which makes the robbers flee fearing a ghost. They finish the leftovers eating as if they would not get nothing more for four weeks, and settle to their individual sleeping places.

After midnight the robbers send one of the group back to check the situation in the house. Now each of the animals uses its individual capacities to fight back: spitting, scratching, biting, blowing, crying. Very frightened, the robber runs back, and from that time forth, the robbers did not dare go back into the house. However the four Bremen Musicians liked it so well there, that they never left it again.

You have undoubtedly noticed how often the relation to music is being made within this story: there are musical instruments, the voice, and the joint music making. And these hints are being topped by the donkey, who is somehow the leading and initiating animal, and his remark: "We're are going to Bremen. You can always find something better than death. And when we will make music together, it will be of something of a special kind.

Therefore the key words, which are relevant for music therapy, in the tale are:

We will always find something better than death.

We will make music together.

Analogies from typical tale features to refugees

1. starting situation:

- interruption of a good development by human made violence,
- leading to lack of essential security, loss of home
- leading into a situation as a displaced person
- question of life or death
- feeling of despair, sadness, hopelessness
- feeling of isolation
- living at the margins of society – hunger, poverty

- needing good advise
- 2.** Way of the heroes: Must overcome one or many dangerous situations:
 - the situation of the escape itself,
 - the long travel through the world deprived of material ressources (food, house, no family),
 - uncertain arrival in unknown countries
 - fighting for a new and secure place (legal and juridical, application as asylum seeker, recognition or not, deportation or not,

Now, refugees usually have no magic to survive all this.

But, what helps them on their dangerous passage? There is help by friends, by assisting NGO's or human rights organisations, and, hopefully, remaining strength to survive. They are challenged to defy their miserable destiny only be developing the goal of a new shape or a new period of life = restoring of self respect, discovering of ressources

- 3.** The answer, the solution
 - There can be partly or general salvation = through own forces, therapeutic assistance, acceptance of the new situation
 - Marriage: seldom, but happens
 - The evil-doers being punished: more seldom, but thinkable in case of political changes and torturers being brought to justice.

Analogy to stressed old people

Our interpretation of the tale describes the similarity also to senior adults who have in their earlier years not been very creatively active, but who do discover their artistic creativity in their senior years. This creativity may be considered as a form of self therapy, as self consolation or as a tool for increase of self esteem.

If we want to help old people and organize very well their leisure time, we ought to have a sensitive staff who is very good prepared to work with old people. This was the reason that I did some research on understanding the fairy tale "The Musicians from Bremen".

The participants were 40 students of Pedagogy in Art Therapy Specialization from A. Mickiewicz University in Kalisz city (Poland).

TABLE 1. Answers to research question

| | |
|---|---|
| I don't like it (3) | <p>I don't like sly fellows and cunning</p> <p>They (animals) achieved this place to live through violence and intimidating. I don't accept these methods</p> <p>These animals don't make music, only noise</p> <p>Where is Bremen in the fairy tale – I don't understand the title of the fairy tale</p> |
| Understanding of educative potential | <p>Fairy tale says that we ought to treat animals very well, because many people treat animals badly</p> |
| Transfer to social problems (28) | <p>bad fortune of the old people in society:</p> <p>no place in family house</p> <p>they have to go to nursing home (In Polish morals, adult children ought to care of old parents)</p> <p>Robbers house is a metaphor of a nursing home: for many people there life is better than in the family house</p> |
| Transfer to humanitarian solutions (8) | <p>It is a wonderful mirror of contemporary world:</p> <p>some times rejected people can gather and make a group of friends to become happy and to start believing in themselves.</p> <p>If we are together we could effectively fight against evil</p> <p>I like the fairy tale because I always take the part of rejected people</p> <p>The fairy tale tells about friendship:</p> <p>thanks to friendship we can achieve more and cope with great difficulties in our life</p> |

Legende: Results of answers to the research question: Results of answers to the research question: What is your understanding of the tale „The Bremen Town Musicians“?

N = 40 students of Pedagogy with Art Therapy specialization = 38 female, 2 male
Location = A. Mickiewicz University in Kalisz city (Poland).

Conclusion:

Creativity is the ability that we have in giving new answers to the situations presenting themselves before us. It's the “antidote” of rigidity, a trend that comes with the aging process, both physically as well as mentally.

In the last few years there is a significant change in the profile of the population in Poland as well as in other European countries, a sensitive one that can be observed in numbers as well as in cultural and social changes. The percentage of individuals of age 65 and over, is going to increase. This change in the demographic profile of the population can also be seen in cultural terms.

The “new” old age population has the effect that demands for services in many areas and for different concepts of aging and being old, and how we view the elders segment, are created. Life review will be an important feature of the therapeutic process for this segment. The prophylactic therapies and activities can play a very important role as the interdependence between physical and mental health is widely recognized nowadays.

When we work with elderly people, we work with people from different backgrounds and histories.

We can say that looking for other formal solutions for own work is a metaphor for looking for new patterns of behavior and belief.” Quotation from G. Brioschi: Art as therapy for the elderly.”

To come to the psychological situation of old people in general, I want to refer to Ruth Bright’s observation, that adult children do move away because of business life, but old people feel the lack of company and practical instances of family affection. Isolation is a common phenomenon among our ageing population, and for many it is the cause of deep loneliness and ,perhaps, of consequence, depression. We see isolation not only in people who are living independently, but also amongst people who are in hospital for rehabilitation and are living in nursing homes.

But social relationships can be developed, enhanced and reestablished with the help of music-based programmes, whether we are looking at old-established family-links, building new bridges between residents in a hostel or nursing home, or helping to strengthen and re-establish the intimate bonds which have been strained by long illness or prolonged time in hospital.

WORKING WITH THE RESSOURCES OF TRAUMATISED REFUGEES

To come back to traumatised refugees - and almost all refugees are traumatised - , they may find their way within Germany to psychosocial centres, called REFUGIO. I am working on an hourly basis for this institution. The Bremen center is now 15 years in existence, similar associations exist in several cities through the financial help of the communities, churches , UN High commission for refugees and the UN foundation for torture victims. The work is done by a network of interpreters and

professionals on a social, medical and therapeutic level. The three people I have been working with in the last year have come from former Yugoslavia, Turkey and Sri Lanka. Common to them is, that they suffer from a series of somatic and psychosomatic illnesses, which have to be taken seriously and examined. When we see people with PTSB = Post traumatic stress disorder according to WHO 1994, we know that they have lived through "events of short or long duration bringing with them extreme danger of catastrophic dimension, which could cause deep despair with almost every man". The REFUGIO concept goes beyond the WHO definition, as it differentiates short traumatic events from longlasting and repeated traumata, and as it differentiates between man made disasters, catastrophes and accidents.

Refugees and asylum seekers are generally forced to stay idle because of not being allowed to work. Therefore it is important to try to establish a timely structure with them. And it is important not to remain where they are in their attitude to the world, but to help develop positive resources. We must insist that there is the lifetime before and after the trauma and not remain at the trauma.

I would like to give an example. My client is a 38 old year old Tamil man from Sri Lanka, who finished school at 17 years with ordinary level and could not go further due to the Sinhalese repression towards the Tamil population. He then joined politics, was involved with the Tamil Tigers movement, was betrayed and arrested. He then suffered 6 years of military and police prison, including severe torture. He gave a very unstable impression when I first saw him. His response to the therapeutic setting is very positive: he can make use of the therapeutic relation and possibility for creative musical expression. His favorite instrument is the marimbaphon whose sound he loves for its warmth and clearness. He also has discovered, or better: rediscovered - the joy of singing. He once sang completely free a long song, that turned out to be a fisher men song. Translated into English, the words are about the following:

We are born on the land, but we go onto the ocean, we find ourselves in the middle of the ocean and are far away from the land, where my wife and the children are. I remember them, although we are far away and we have no connection. They also think about with sorrow and look out, when I will be back.

On the ocean, there is always the possibility of thunderstorms, then I will be in great danger, and maybe I will perish very fastly without being helped by someone. Also, if I need to drink water, no one can provide me with water. I am all alone there, far away. I hope that the Gods will protect me, and that they do see me, all alone far away on the ocean.

His reaction on listening to the music and also to a short taped piece of conversation between us before the song: that's my voice, that's my voice, I have never heard it.

Then he hummed to the song, while getting more and more quiet and sad, and then broke into a spontaneous sobbing, followed by long crying. Then he said: you know, in Sri Lanka, people never told me how to talk correctly, they always said, oh you, you cannot even talk how it is expected. And now – you talk to me and I feel so respected.

Question: do you like it to hear yourself talk

Answer: Oh yes, very much - and then he was shaken by another outbreak of crying, for which he excused himself later.

I concluded the session, saying: next time we continue recording and making music, and he laughed.

The theory of music therapy establishes some goals of intervention, one of which is to contribute to the restoring of identity. Now, this man can get back a part of his broken identity by rediscovering his social roots, expressing his creative singing and therefore integrating the pain of humiliating experiences of the past into the present awareness of himself.

Conclusion

In the course of the presentation, we both found how important it is to learn more about the working conditions of us professionals within Europe. This knowledge, however, is the base to build our music therapeutic profession and can lead to connecting, teamworking, and networking.

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CHAPTER 66

Alex – An ongoing research on alexithymia and regulative music therapy

Wosch, Thomas

In psychotherapy, after the emphasis on bonding theory of the recent years, the pre-occupation with alexithymia has become the most important topic in the field of psychotherapy and psychosomatics. Issue no. 2/2004 of *Psychotherapy and Psychosomatics* is dedicated solely to alexithymia. This disorder already forms a very large area of research. Graeme J. Taylor, one of the most renowned specialists in the subject, underlined this fact in the lead article of the issue by pointing out that in *PsychINFO* we can currently find over 1000 articles about alexithymia. As is to be expected, several measuring methods for alexithymia, as well as therapeutic approaches, are discussed in the following articles of this issue of *Psychotherapy and Psychosomatics*, but not a single word is said in this context about music therapy. Nevertheless, music therapy in particular can offer a very special contribution to therapeutic approaches for treating alexithymia, which will be the focus of my paper. I will show this by the example of first preliminary results of a study about alexithymia and receptive music therapy. In the following I will briefly talk about the disorder of alexithymia: afterwards I will introduce the design of the study and its preliminary results.

Alexithymia is a term for a disorder from clinical psychology, which was named and discussed first by P.E. Sifneos in 1973. Contemporary understanding defines alexithymia as follows: "... alexithymia involves a deficit in symbolisation in

which the somatic sensations associated with the states of emotional arousal are not strongly linked with images and words.” (Taylor & Bagby 2004, 70) The original meaning of an inability to name emotions (a-lexi-thymia) is here differentiated by the lack of symbolisation of emotions and their physical expression (emotion, the status of body and soul, Ulich 1992) through language and associations. This deficit in symbolisation will play an important role further on for the disorder-specific choice of corresponding music therapeutic approaches. But it becomes clear already in the definition of alexithymia that especially music therapy can be the means of choice with its very specific presymbolic opportunities. Alexithymia in itself is not a disorder that can be found in diagnostics like ICD 10 or DSM IV. Rather it is a very complex symptom, which appears primarily with somatoform disorders, however it is also discussed in connection with affective disorders, obsessive-compulsive disorders, abuse and today even commonly in personality and social psychology. A recent Finnish study even came to the conclusion “that alexithymia might be related negatively to survival and longevity.” (Taylor & Bagby 2004, 75; Kauhanen e.a. 1996). This means that alexithymia forms on the one hand a specific part within various disorders as a symptom as well as a spreading concept of explanation for psychological disorders. Further differentiations for alexithymia name a psychological processing of emotions that is disturbed by the disturbed perception and verbalisation of emotions (Kupfer e.a. 2001, 5). This goes especially for the externally oriented style of thinking – the pensée opérationnaire (Marty & de M’Uzan 1978) – of alexithymia. With this is described that in problematic situations the possibility for analytical thinking is not given, i.e. no reflection about solutions can be observed. It is very interesting that this is described as a problem of adaptation demand in the sense of cognitive learning theory (Kupfer e.a. 2001, 16) even though alexithymia originated from a psychoanalytical background. This implies in the sense of the most modern psychotherapy a further comprehensive, here approach-comprehensive character of the alexithymia concept for the subject of psychotherapeutic approaches for psychological disorders. In total we can name three components that characterise alexithymia as a phenomenon: a) disorders in the identification of emotions, b) disorders in describing emotions, and c) the already named externally oriented style of thinking (Kupfer e.a. 2001, 15-16).

In the issue of *Psychotherapy and Psychosomatics* that was already named above, especially the Toronto alexithymia scale is emphasised for measuring alexithymia in several articles and even in the named lead article by Taylor (TAS 20 / TAS 26). With 20 self-assessing questions in English and 26 in German, the three aforementioned items of alexithymia are imposed. With this measurement instrument, which was also completed in 2002 for the German market, a research cooperation between University of applied sciences Magdeburg and the Erlabrunn Clinics gGmbH was reached. Very special thanks at this point to Dr Helmut Röhrborn who is the head

physician of this hospital and donated very substantial contributions to the further development of Regulative Music Therapy, which is also relevant here. In this hospital we conduct a comparative investigation about alexithymia with clients in verbal psychotherapies and music therapies. This study we called “Alex.” The Erlabrunn Clinics gGmbH offer a particularity that so far has not been used for comparative studies of different therapeutic concepts. Here, among other applied therapy concepts, two closed therapy groups with the emphasis on Regulative Music Therapy and dynamic group are conducted, the latter of which is a special verbal psychotherapy concept that is based particularly on the intensive use of group dynamics. For research this is an opportunity to examine comparisons between the results of the different concepts. And this is not conducted in a laboratory environment, but instead uses the particularities of an undisturbed or otherwise influenced clinical praxis. In psychotherapy research since the mid-nineties (Hilliard 1993), as well as in recent music therapy research (Wigram 1999, Wosch 2002, Ridder 2003), the formerly demanded connection between the quantitative research and laboratory environment is broken. It is also possible in a natural setting to work, under newly put questions and perspectives, with quantitative measurement instruments and, for example, to investigate a phenomenon like alexithymia. In doing so, it does not work in these cases of quantitative investigations that occur in a natural clinical setting, to concentrate solely on the verification or falsification of a thesis. It can rather, just as in quantitative research, lead to a hypothesis development at the end of such a research process. This goes also for the Alex study, which will, at the end of my paper, lead to the formation of a hypothesis and then to direct effect studies only on the basis of first results. In the end it is an important question with these special quantitative procedures whether one can find a particular clinical setting that offers a very special suitability for particular investigations. In the case of the Erlabrunn Clinics gGmbH this is given in several respects.

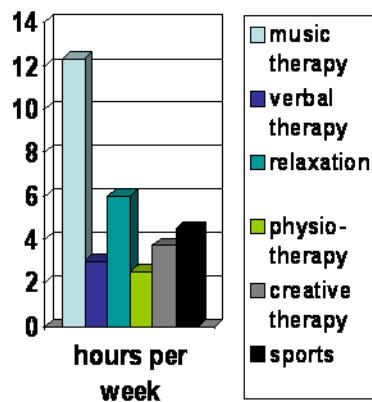
Research-specific clinical setting

- **Example of the Clinics Erlabrunn gGmbH:**
 - special test department (different tests)
 - follow-up groups of all clients
 - application of Regulative Music Therapy (RMT) where particularities of alexithymia are used as a theoretical basis
 - particular settings of different therapy concepts

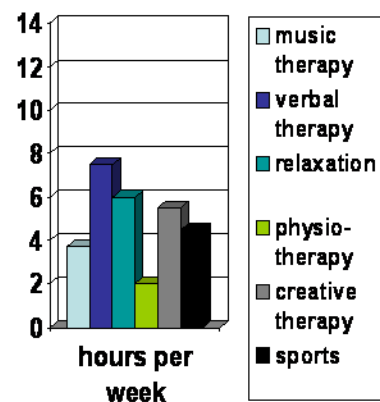
On the one hand there is a small department of so-called test-nurses, who share certain duties in the implementation and interpretation of the psychological tests with the psychologists. Considering that it is only a small extra effort for the hospital's capacities of personnel to introduce a new test, as in the case of the Alex study with the TAS 26, and to retain its data for interpretation. With hundreds of patients a year, there is also a large amount of data to be collected, which then has to be differentiated in a second step. With Alex, we are aiming at getting the data of a thousand patients in total; so far we have 308 sets of data. For all patients we also keep further tests, for example the symptom checklist (SCL 90 R), which also can be used for the investigation. Moreover, patients are invited to participate in follow-up groups after one and two years in order to receive information about the further course of the changes that were or were not brought about by the therapies. This can also be combined with questioning through tests, which in turn allows long-term follow-up results to be won. As a third point, Regulative Music Therapy is applied here, which in its theoretical basis already names single aspects of alexithymia. Finally, different therapy concepts are very much differentiated for the

individual patients here, so that each patient receives various individual therapy offers that are in themselves consistently described and carried out. You can see this on the following slide, which illustrates this point with the example of the two already mentioned therapy groups.

RMT setting



Dynamic setting



In the bar graphs you can see the temporally different therapy portions that both of the client groups receive in this clinic. Specifically, it means this: For the group with the emphasis on Regulative Music Therapy, 6.5 hours Regulative Music Therapy, which is visible here as the largest portion, 3.5 hours reflecting on the day every evening with music reception and finally 2 hours of active group music therapy are offered. In the other kinds of therapy the relaxation training (autogenous training) with 6 hours a week and sport with 4.5 hours a week are the largest components. The Regulative Music Therapy is here seen as the focus of the therapy setting. Its processes are seen as authoritative for the aims for all further therapies in the coordination of all therapies and treated in the cooperation with single therapists. For the second group the largest part in time, as well as in content, is on ver-

bal group therapy oriented on group dynamics with 7.5 hours per week. On a time scale this is followed – just as the first group – by autogenous training with 6 hours a week. In this concept the creative therapy comes third with 5.5 hours weekly. You can see very clearly just by looking at the time components that the patients of the Regulative Music Therapy group, as compared with the dynamic group, have a much bigger music therapy portion; on the other hand the dynamic group receives a larger verbal component. Both of these natural therapy settings together with three further settings form the starting point of the Alex study. The other three settings are being modelled more individually for every patient, in which the first of these is for all patients a training in self-perception, the second active music therapy and the third varying concepts of verbal individual therapy / Dyad. In the Alex study we ask for possible differences between the patients treated with different therapy settings with regard to the patients' diagnostics and special further psychological symptoms. In the end, this general question leads first to my hypothesis formation that is then examined in the clinical praxis without further influences.

Before I come to the general design of the investigation and, with this, to the first preliminary results of the Alex study, I want to briefly introduce the music therapeutic approach of Regulative Music Therapy. It is well known in Germany, though not internationally, which is why I will briefly discuss it here. RMT is a receptive method of music therapy. The development of RMT began at the university hospital in Leipzig, Germany, in the sixties. There the founder of East-German music therapy Christoph Schwabe was entrusted with the practical implementation and theoretical investigations of a music therapy. The most widely used method to date, within his differentiations of music therapy method, is the Regulative Music Therapy. Today it is used as psychotherapy for groups and unfolds in six phases during self perception training. Röhrborn, whom I mentioned above, was primarily involved in its final structure and development. A group session of RMT takes approximately 60 minutes. The session begins with the self perception training accompanied by music, and during this initial phase the patients can be advised as follows: "Try to let your body and the music take over and don't push away the arising thoughts, moods or feelings" (Schwabe & Röhrborn 1996, 60). The group usually consists of 6 to 12 patients who sit comfortably with their eyes closed. Some music, usually one or two symphony or instrumental concert movements, is played for about 10 to 20 minutes. During this time, the patients try to let go and achieve a state of perception, similar to a state of daydreaming, in which they actually start observing themselves. When the music is over they are requested to adjust their physical balance in order to regain the state of full consciousness and begin with the therapeutic conversation. In the course of the conversation, patients speak about their different perceptions. The impact of particular perceptions is strengthened, and since the conversation is held within the group, the patients recall more percep-

tion details and they are guided and encouraged by the therapist to explore the acceptance in the perception. This leads to a process as outlined in the following slide, which takes, for example, seven weeks in Erlabrunn where RMT is applied every day.

Regulative Music Therapy (RMT)

- 1) "broad" perception
- 2) "deep" perception
- 3) emotional reactions on perceptions
- 4) differentiation of accepted and non accepted perceptions
- 5) detailed perception of non accepted perceptions
- 6) training and transfer of perception regulation

(Schwabe & Röhrborn 1996, 59-71)

In phase one, as you can see, broad perception takes centre stage: To let go and to accept are the main tasks which have to be performed just like in the first form of Regulative Music Therapy. The focussing of perception on single moments or tensions is replaced by a broad perception of music, body, thoughts and feelings in the centre. If this has been achieved, phase two begins which is based on deep perception. Now single elements such as the beginning of the self perception training or the flow of perceptions shortly before or after the physical awareness are experienced more distinctly and described. A process is initiated in the course of which the capability to perceive one's own inner processes is further enlarged or deepened. In RMT, this can lead to the patient giving a very clear and distinct 10-minute description of a certain moment, which took no more than three seconds in the

actual training session with music. This is when our selective perception and also our defence mechanisms become unstable. In the following third phase, emotional reactions on perceptions can be observed. Each particular awareness of the body as well as emotional perceptions are now experienced in an emotional reaction. What otherwise is not perceived clearly enough in our daily activities, often for our own protection, is now perceived emotionally with emotional reactions every second. After this step we begin to differentiate between accepted and not accepted perceptions. In this particular context not accepted perceptions mean that "defensive emotional reactions" (Schwabe & Röhrborn 1996, 65) or the "wish it would be different" (ibid.) are connected with such perceptions. The fifth phase follows immediately, in which we turn to the not accepted perceptions. The "going against" factor of not accepted perceptions is strongly felt by the patients themselves in the course of a precise self-awareness and can be adjusted by them. If patients stop refusing their perceptions, they no longer nurture and sustain them and even start working on particular not accepted perceptions. In phase 6, much emphasis is put on regulation including exercises for daily life, which can be individually practised by the patient. This is, in short, a description of the main procedure and some of the basic principles of RMT. The focus and differentiation of self-perception in RMT was thereby discussed, also before the background of the aforementioned component of alexithymia of an externally oriented style of thinking, where RMT could potentially offer a very good approach. Moreover, as a receptive music therapy RMT offers a proceeding that, gradually, can be oriented very much on the body of the patient as a first description level. The ever further differentiation of the own perceptions, the devotion to not conscious details of inner perceptions between body, thoughts and emotional reactions, can contribute substantially to the therapy of dysfunctions in the identification and description of emotions, as described above for the alexithymia. On the contrary to BMGIM, which is connected from the beginning with symbolisations on the level of images that are just disordered in alexithymia, RMT can show a different approach to the client through the medium of music reception and is especially relevant for the therapy of alexithymia and its fundamental problem of symbolisation. Still, in Alex's current stadium such a comparison is not the field where alexithymia is being analysed, but the investigation of the above named five therapy concepts of the natural clinical settings of Erlabrunn.

The comparison between the different therapy settings was performed with the following investigation inventory / research design.

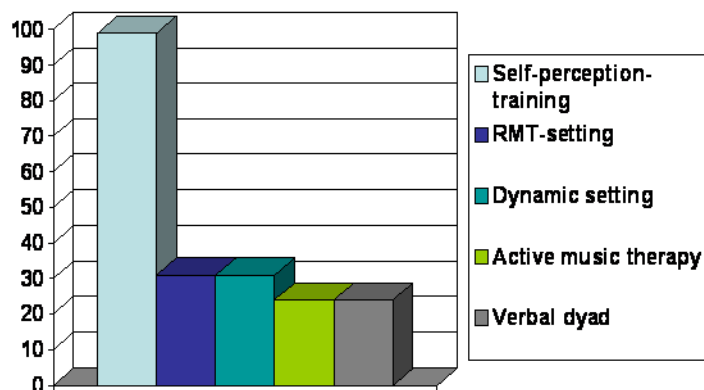
Alex-related data

- **Social data**
- **Main diagnosis (one, ICD 10, F)**
- **Pre-post-data SCL 90 R (symptom checklist with 9 psyche dimensions and one sum)**
- **Pre-post-data TAS 26 (Toronto alexithymia scale with three alexithymia items and one sum)**

For every patient we raised social data such as age, sex, profession or job, and school qualification. Also an ICD 10 diagnosis of field F, the psychological disorders, was determined as main diagnosis. Furthermore, we established the symptom checklist SCL 90 R and the Toronto alexithymia scale TAS 26. With this investigation inventory the alexithymic problems of all patients were measured, as well as important psychological symptoms with the SCL 90 R, which partially, as described above for alexithymia, reach over to different psychological disorders and give very important information about indication questions besides the ICD 10 diagnosis and the alexithymia values.

And now is the crucial moment – which preliminary results do we have for our Alex study with the first 308 patients? Before we will be able to see that, we are going to look at the next illustration of the number of patients treated in those five therapy concepts.

Therapy concepts of 209 patients



Hereby we reduce the number of 308 to 209 sets of pre-post-data that are as yet completed. For 99 patients we have until now only the pre-test. From the 209 complete sets of pre-post-data, 99 patients were in the self perception training, 31 in each group concept for Regulative Music Therapy and the dynamic group, as well as 24 each in the concept for active music therapy and the different dyads. It is actually pure chance that we have the exact same number of patient data for the Regulative Music Therapy and the dynamic group, and with such an amount it is possible to evaluate the data statistically on the lowest level, which again enables us to make a comparison even between just these two groups. Naturally, though, you need to observe the respectively different profile in the diagnosis of the different groups. Those are in comparison to the respective rate of their frequency 1 or 2 shown on the following slide.

Main diagnoses of different concepts

- Regulative Music Therapy: somatoform disorder (N=12); depressive disorder (N=8)
- Dynamic Group Setting: phobia and anxiety disorders (N=9); depressive disorders (N=8)
- Self-Perception Training: depressive disorder (N=33); personality disorder (N=32)
- Active Music Therapy: depressive disorder (N=11)
- Verbal Dyad: depressive disorder (N=6) & somatoform disorder (N=6)

With the Regulative Music Therapy group, the largest part is characterised by somatoform disorders, followed by depressive disorders. In the dynamic group, on the other hand, anxiety disorders and depressive disorders are most prevalent. The self-perception training was used as a treatment especially for patients with depressive and personality disorders. Also in active music therapy patients with depressive disorders were mostly getting their psychotherapeutic treatment. Finally, in the verbal dyad there appeared mostly the diagnosis of depressive disorders and somatoform disorders. The largest group of disorders in need of treatment are the depressive disorders, which corresponds exactly with the German statistics of psychotherapy. Those depressive disorders are being treated with all five concepts, though with the apparent emphasis in the direction of the second diagnosis. This nonexistent homogeneity of sometimes different diagnosis groups in the different therapy concepts needs to be acknowledged with all the consequences for the further evaluation. But the questions about alexithymia allow us to presume different tendencies in just this natural setting and with just these diagnosis emphases. With the different diagnosis profiles as well as with the different therapy concepts we can presume a different

relevance of the alexithymia problem. The answer to this – and the preliminary results of Alex – will be shown by the next slide.

Alex – SCL & TAS significances

| Test / Concept | SCL gsi | Soma tisa tion | Obse ssive- Com pulsive | Inter Perso nal Sensi tivity | Depr essio n | Anxi ety | Hosti lity | Pho bia | Paran oia | Psy choti cism | TAS total | Ident | Nam e | Pen sée |
|-----------------------------------|---------------|----------------------|----------------------------------|--|--------------------|---------------|---------------|---------------|---------------|----------------------|---------------|----------------|---------------|----------------|
| RMT | ,000 | ,000 | ,003 | ,013 | ,000 | ,000 | ,005 | ,000 | ,002 | ,002 | ,018 | ,005 | ,642 | ,321 |
| N=31 | 72-64 | 70-64 | 68-62 | 64-60 | 71-62 | 70-63 | 64-58 | 65-57 | 62-57 | 64-58 | 60-56 | 62-57 | 61-60 | 47-47 |
| Dyn. Group | ,600 | ,306* | ,399 | ,678 | ,269 | ,492 | ,065* | ,026 | ,657 | ,158 | ,100 | ,258 | ,508 | ,524 |
| N=31 | 66-64 | 62-64 | 61-57 | 65-64 | 66-64 | 65-63 | 59-61 | 60-55 | 61-57 | 58-56 | 58-56 | 60-58 | 61-60 | 46-45 |
| Self- perc.- train. N=99 | ,000 72-63 | ,000 64-59 | ,000 69-59 | ,000 67-58 | ,000 71-63 | ,000 69-65 | ,000 63-57 | ,000 66-58 | ,000 63-55 | ,000 67-58 | ,016 60-57 | ,019 62-59 | ,422 60-58 | ,900* 47-47 |
| Ac tive MT N=24 | ,011 70-60 | ,140 66-61 | ,013 66-58 | ,177 62-58 | ,004 70-60 | ,032 68-62 | ,025 59-53 | ,003 65-56 | ,184 60-57 | ,018 65-58 | ,862 56-55 | 1,000 58-57 | ,375 58-57 | ,819* 48-48 |
| Verb. Dyad | ,000 | ,008 | ,000 | ,000 | ,000 | ,000 | ,001 | ,001 | ,000 | ,000 | ,104 | ,007 | ,955 | ,955* |
| N=24 | 73-60 | 68-60 | 70-58 | 67-53 | 74-61 | 70-59 | 61-53 | 68-57 | 64-51 | 66-56 | 61-55 | 57-53 | 56-55 | 45-45 |

Here they are. Horizontally you can see in green and blue the individual and summarised scales of SCL 90 and TAS 26. Vertically are the patients, divided into the five therapy concepts. The numbers are the values of significance, which have been, with regard to the characteristics of the data put in, evaluated after the Wilcoxon test (SPSS). In red are those numbers that show a significant change between the pre and post values of the respective SCL and TAS scale within a 5% level. In many cases you can even see the highest probability, a level of 0%. Overall, there is already a tendency emerging by observing the significant red and the insignificant blue numbers. There are considerably more significant changes regarding the experienced symptoms that reported back from SCL. With regard to the central question about alexithymia, only one significant difference can be observed – specifically the concept of RMT. Here the Regulative Music Therapy shows, in respect to significant changes in alexithymia, the highest status. However, this only goes for *one*

factor of alexithymia and not for the total. That one factor is the identification of emotions. Such a result was confirmed by an analysis of an individual case, which was conducted by Maren Voigt as her thesis of the University of applied sciences Magdeburg in the psychosomatic department of the University Hospital Magdeburg (Voigt 2003). The identified TAS was determined for a process research program after *every* therapy session, and also displayed a clear improvement tendency in that factor of identification of emotions in the overall progress of the regulative individual music therapy. The factor of describing emotions did not display that. The factor of externally oriented style of thinking moved overall in a relatively unproblematic area. Now, with a larger number of patients having been treated with RMT, we can observe an improvement of the factor of identification of emotions also in the clinics of Erlabrunn. This factor seems to play a special role within the construct of alexithymia for the therapy with RMT. There is another parallel between the two studies that is also very interesting: In the single case in Magdeburg the main diagnosis of Morbus Chron was being examined. The close relationship to those somatoform disorders as main diagnosis – depicted on the slide earlier for the RMT – is striking and confirms the diagnosis emphases about alexithymia by Taylor that I mentioned in the beginning. From this we can draw two provisional hypotheses, which will have to be examined during the further course of our study. Firstly: A) There is a special connection between the diagnosis of a somatoform disorder and the factor of identification of emotions within alexithymia and its therapy through RMT. Secondly: B) For the basic concept of RMT, the identification of emotions is of higher importance than the externally oriented style of thinking mentioned above. What supports this first hypothesis at this time is the fact that the symptom of somatisation experiences in RMT a change to the highest degree (level of 0%). This also happens in the concept of self perception training, which in principle is very similar to the RMT, though working without the application of music reception. These first results suggest, within the alexithymia problem, the highest therapeutic relevance for the RMT. Additionally, the two therapy concepts of RMT and verbal dyad demonstrate a highly significant difference concerning the symptoms depression and anxiety. Looking further at the symptoms, we can complete the totals by determining that the verbal dyad holds the highest average in the pre-values (mean pre=73; post=60), immediately followed by self perception training (mean pre=72; post=63), again followed by the RMT group (mean pre=71; post=64) and just behind active music therapy (mean pre=70; post= 60). In the dynamic group the number only lies at 65 and sinks down to 64, which is not a significant difference. This means that the patient symptoms (determined by using SCL 90 R) have the highest pre-value in the group of patients of the verbal dyad, immediately followed by the self perception training, followed by the RMT group and the active music therapy group. The patients of the dynamic group only show insignificantly heightened problematic symptoms that consequently do not need to

be worked on – hence we cannot see significant improvements here either. The “lighter” disorders like phobias and anxiety disorder that I named above in the diagnosis emphasis of this group are being empirically confirmed here again. The active music therapy group does not show significant changes in the total values (,011). Therefore a highly problematic symptomatic is being treated foremost in the verbal dyad, the self perception training and in the Regulative Music Therapy. The individually centred concept of Regulative Music Therapy continues – despite group therapy – to become quite clear in the only missing significance in the pathology of interpersonal sensitivity dimension. All three of the just named concepts (verbal dyad, self perception training, RMT) show, however, the highest significant changes in the pathology of depression and anxiety; here seems to lie a commonality in all three of them. One important difference is observed, however, on the one hand with Regulative Music Therapy and on the other with verbal dyad and self perception training. With the RMT an improvement of the alexithymia-factor is achieved, while with the verbal dyad and self perception training there is an improvement of the symptoms, but not necessarily changes in the alexithymia-factor. – It becomes clear with these examples that it is possible to successfully treat very specific psychic problems with very specific therapy concepts. These results can, in an empiric way, lead to a very disorder-specific indication stand about the different therapy concepts. For instance, for Regulative Music Therapy this means the highest effectiveness in treating the symptoms of depression (mean pre=71; post=62), somatisation (mean pre=70; post=64), anxiety (mean pre=70; post=63) and phobia (mean pre=65; post=57) in connection with a partial alexithymia problem (mean pre=62; post=57). This is happening with a considerably better result when compared with the active music therapy in Erlabrunn. Stronger depression symptoms will however be treated more effectively in the verbal dyad (mean pre=74; post=61), although less effectively in connection with partial alexithymia. In conclusion, this leads us to the hypotheses and perspectives that need to be examined during the further progress of the Alex study.

Alex – hypotheses and perspectives

- There is a special connection between somatoform disorder and identification of emotions as RMT-indication.
- The most important alexithymia-item in the concept of RMT is identification of emotion. —
- Using a huge number of data for comparison of different therapy concepts special complexes of diagnosis, symptom and alexithymia-item lead to different indications for different therapy concepts. (This can be done as effect study in natural settings!)
- Cluster analysis of all data concerning significant changes of TAS-sum value will create new groupings of patients and therapy concepts beside the five described above.

It is anticipated that with an even larger number of pre-post-patient-data we can, in the different therapy concepts, compare respectively one diagnosis and one symptom group of patients with similar starting data ($N > 20$). For one thing, this can give the indication for a diagnosis, symptom and alexithymia complex (for example with RMT: somatoform disorder, emphasis on depression and problem of identification of emotions) with one certain therapy concept. This makes a study of effects possible, from practical application and experience and out of an abundance of material, and without having to work in a laboratory environment. This gives the music therapy research new conditions that are much better to realise. Also, for the treatment of such a complex of diagnosis and symptoms there are different therapeutic ways emerging, for example with or without the treatment of alexithymia parts. Within this frame it could further be examined whether the identification of emotions as a theoretic basis of the alexithymia construct will be definitely confirmed within the overall concept of RMT and its particularities compared to the other therapy approaches that have been examined here. Additionally, it is possible to search for further groupings apart from these five therapy concepts by means of a

cluster analysis, since for all examined patients a significance of 0% for the TAS total value, as well as for the partial factor identification of emotions, had been determined.

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CHAPTER 67

*Examining Significant music therapy
experiences from the perspectives of*

*individuals living with
HIV/AIDS*

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(Portions of this material have been previously published in the Book of Proceedings of the 30th Annual Conference of the Canadian Association for Music Therapy 2004)

Background to the Inquiry

This study was completed in conjunction with my master of Music Therapy degree (2002-2003). The topic emerged as a result of eight years experience as a music therapist and Canadian health care professional where my passion for clinical work and my belief that clients' perspectives must be the main consideration guiding music therapy practice have remained steadfast. I decided to examine work with individuals who are living with HIV/AIDS because of personal interest in this clinical population as well as practical considerations that necessitated a timely completion of the project.

Related Literature

The history of HIV/AIDS and music therapy intervention is relatively brief given that anecdotal reports of the illness first surfaced in 1979 (National HIV/AIDS Volunteer Training Kit, 1998). We do not have time today to engage in a detailed review of the music therapy/HIV literature. Notable contributions include: Maranto (1988), Rykov and Hewitt (1991), Bruscia (1995, 1996), Hartley (1999), Neugebauer (1999) and Lee (1989, 1990, 1992, 1995a, 1995b, 1996, 2003). Increased knowledge, earlier diagnosis and better treatments mean that persons who are currently living with HIV/AIDS can achieve longer and healthier lives. Clinical work and literature is currently changing and expanding to address issues specific to those who are actively living with the virus in addition to those who are in the palliative stages of the disease.

Clients' perspectives on music therapy experiences are sometimes difficult to ascertain as much of the work involves persons who have communication barriers. To gain a valid and reliable understanding of this area is also methodologically challenging. Investigations or interviews may be considered invasive for some clients or have negative impact upon the therapeutic process. Again, we do not have time for an in-depth review of the literature. Notable contributions include: Aigen

(1995), Arnason (1998), Amir (1992, 1993a, 1993b, 1996) and Lee (1996, 2003). A particularly relevant publication in this area is *Inside Music Therapy: Client Experiences*, edited by Hibben (1999). There is a need for more literature and sensitive inquiry into clients' perspectives on music therapy experiences.

Methodology

The research paradigm is qualitative, descriptive, explorative and non-positivistic in nature. It does not investigate causal relationships between variables but looks to describe how specific interventions unfold within the music therapy session. The use of inductive reasoning allowed descriptive themes/ideas to emerge with the data as experiences presented themselves. My epistemological viewpoint is based on my belief in each client's inherent ability to know what he/she needs. These expressed or implied needs are then used to guide the therapist's treatment approach/interventions within a flexible knowledge base. The research model is multi-methodological and draws upon elements of naturalistic inquiry, grounded theory, phenomenology, phenomenography and hermeneutics.

It was essential to represent each client's unique perspectives on, and responses to, music therapy experiences that would somehow be identified as important or significant. It was also important that the clinical process remain unaffected by the research. The research questions address these aims:

1. How do individuals living with HIV/AIDS spontaneously verbalize/respond during/following significant music therapy experiences?
2. How might the verbal dialogue/responses be organized into categories?

Upon formulating these questions it became necessary to define the term "significant experience". Similar terms in the literature include "peak experience" (Maslow, 1962; Lowis and Touchin, 2002), "critical moments" (Pavlicevic, 1988), "pivotal" (Erdonmez-Groce, 1999) and "meaningful moments" (Amir 1992, 1993a, 1993b, 1996). In my study, the music therapy experiences being described and analyzed are a direct representation of what occurred in the "natural" clinical setting as opposed to a formalized research environment. The therapeutic process as it emerged is reviewed with no "after the fact" reflections from the clients. The clinical approach with each client was individualized. It was developed as a result of each person's expressed and implied needs as well as through the natural evolution of the therapeutic relationship, both musical and interpersonal, over the intervention period. Therefore, it is not appropriate to define or label the experiences in

the same way for each client. The term “significant” implies that an experience may stand out for an individual but it does not imply the reason why. Therefore, “significant experiences” were defined and identified differently for each client based on the descriptions and analysis of each individual’s unique music therapy experiences and supported by patterns that emerged from the data. This will be further clarified in the Results section.

There were 2 individuals involved in this study, who had (between them) a total of 37, one-hour sessions over an 8-month period. All but 2 sessions were audio recorded and portions of these sessions were analyzed using a method referred to as indexing.¹ These notes as well as analytic memos were maintained as part of standard clinical practice and later employed as sources of data. Upon completion of the intervention period, all recorded sessions were reviewed sequentially for the purpose of gaining an overall sense of the therapeutic process for each client. This aided in the formulation of additional descriptive notes and clarified which interventions would be defined and identified as “significant experiences” and subsequently analyzed. This analysis involved the formulation of a thorough description of each intervention using indexing notes, analytic memos, descriptive notes and audio recordings as references. All of the audible responses and verbal dialogue that occurred during and after each significant intervention was transcribed verbatim. The transcripts were analyzed by means of several steps (with reference to Colaizzi, 1978 in Forinash, 1995). Repeated analysis of the transcripts were conducted over 4.5 months in order to gain perspective on the data as well as to force continuous questioning regarding my level of interpretation. Categories and themes were reordered and restructured several times in order to represent each client’s perspective as accurately as possible.

Four criteria as outlined by Lincoln and Guba (1985) were employed to examine the trustworthiness of this study. These include: credibility, confirmability, transferability and dependability. I am happy to answer any questions in this area if anyone requires clarification.

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1. “Indexing is a form of evaluation that describes, assess and interprets the music therapy dialogue. Listening back to the session the therapist will stop the tape at salient points, note the counter number and transcribe through words and/or music the meaning and intent of the segment.” (Lee and Khare, 2001, p. 250).

Results

Repeated analysis of the responses and dialogue that occurred during and after ten identified significant music therapy experiences revealed broad categories under which clusters of themes were placed. Separate categories/themes were developed for each client.

Because of time limitations, I will present 2 brief excerpts from the results. It is hoped that a more comprehensive publication of the results will be made available in the future.

EXAMPLE #1

L. is an adult male in his late 30's who is living with HIV/AIDS. He struggles with clinical depression and has undergone treatments for cancer in his leg. He has lived in several countries where he has been surrounded by social and political turmoil. His family has experienced violence and they have suffered significant losses and separations. English is not his first language. L. attended 21 music therapy sessions over an 8-month period where many of these issues as well as day to day struggles and joys were addressed through instrumental and vocal improvisation, singing, song writing, music listening and discussion.

Initially it seemed difficult to choose significant experiences from the sessions with L. and articulate why they could be defined as more significant than others. This was because L. seemed to have consistent responses and possibly meaningful experiences in most of our sessions. However, as the therapeutic relationship progressed, it became obvious that the use of particular interventions gained importance and prominence within the sessions. This was the direct result of requests and choices made by L. Therefore, experiences where these interventions were employed are defined as significant. These interventions include free improvisation, improvisations that incorporated relevant cultural musical material and the use of pre-composed songs. A total of seven of L.'s experiences were described and the dialogue/responses that occurred during and after each intervention were transcribed and analyzed. Because it was not possible to describe and transcribe all of the experiences where the prominent interventions occurred, experiences were selected where L. chose to engage in dialogue with the therapist after the intervention (not always the case). It is interesting to note that I inadvertently chose examples that seem to be somewhat representative of the therapeutic process in that they begin at session 8 and are more or less evenly spread out over the remainder of the intervention period.

There was one session where L. said very little as he arrived at the music therapy studio for our scheduled session. He put a large gathering drum and gong by his chair. He began to vocalize a Jewish melody and I joined him using my voice and the piano. This improvisation lasted 30 minutes and the music seemed intense and urgent – particularly when L. spontaneously began to chant prayers in Hebrew. (musical excerpt played here)

Afterward, L. explained to me that he was praying for the people of Iraq. This session occurred right around the time the war began. These prayers were all he could offer. He wished he could do more but he had his own battles to fight with HIV. He said, “I have my own war...I am a warrior and everyday I fight with my armour and sword...the music makes me strong.”

An analysis of the responses/dialogue (refer to Table 1) shows an emphasis on embracing the positive and accepting what life has to offer (13 references to C14). There are also several references to the support/help he provides to others (6 references to C8) as well as the ways in which he helps himself (6 references to C9). The musical references (Category B) are somewhat evenly spread across themes (2-4 references to each one). It is interesting to note that even though the improvisation was largely based on fragments of Jewish melodies, there are no verbal references to cultural issues (C13).

TABLE 1. L.’s Categories/Themes based on the analysis of the responses/dialogue that occurred during/after 7 identified significant music therapy experiences

| A. Physical Responses | B. Musical References (References to:) | C. Personal/ Interpersonal References (References to:) |
|---|---|---|
| 1. laughing, crying, clapping, sighing... | 2.a...the music/instruments used in MT sessions | 7...people who support him |
| | 2.b...the lyrical content of music used in MT sessions | 8...the help, advice & support he provides to others, his experiences serve as a resource |
| | 3...feelings, images, responses evoked by the music | 9...his self-reliance, determination & fighting spirit as well as the ability to make his own decisions |
| | 4. Use of instrument sounds /singing to demonstrate an idea or make a point | 10...day to day/overall struggles & difficulties |

TABLE 1. L.'s Categories/Themes based on the analysis of the responses/ dialogue that occurred during/after 7 identified significant music therapy experiences

| | | |
|--|--|--|
| | 5...musical experiences that occur(red) outside of the music therapy setting, includes discussions about musical material not previously offered in sessions as well as personal opinions on music | 11...feelings & thoughts, these are reflections of his " <i>personality</i> " & of his " <i>humanity</i> " |
| | 6...how music is helpful, important & has the ability to express things | 12...conversations & quotes, what others say to him or about him |
| | | 13...cultural background /experiences/language |
| | | 14...moving on from the past, enjoying the present and looking towards the future, includes embracing the positive, rejecting negativity, the use of humour and accepting what life has to offer |
| | | 15...to past & present experiences as well as anticipated events in own personal life |
| | | 16...to the music therapist, L.'s experiences of MT, the therapeutic relationship, other experiences of therapy |

EXAMPLE #2

O. is an adult male in his late 30's who has been living with HIV/AIDS for over 20 years. He has undergone multiple losses in his life including the fairly recent passing of loved ones. As a child he was subjected to repeated occurrences of sexual and physical abuse that continued into his adolescence. He reports having an unspecified learning disability, which went undiagnosed during his school years. O. has experienced periods of extreme physical deterioration as a result of HIV related illnesses but his current condition appears to be relatively stable. O. attended 16 music therapy sessions over an 8-month period where past and current struggles surrounding the abuse issues were addressed through instrumental improvisation, song writing, music listening and discussion.

In contrast to L., O.'s significant music therapy experiences were readily identifiable and more easily defined. The four identified experiences seemed to contain intense connections and aesthetic responses to the music that did not appear to be present at other times. On separate occasions (with no prompting), O. himself identified three out of four of these experiences as being particularly important/significant occurrences. In all four experiences, O. also demonstrated observable

emotional responses (i.e. crying), followed by verbal processing (initiated by O.). Three of these four identified experiences (the 4th was not audio taped) were described and the dialogue/responses that occurred during and after each intervention were transcribed and analyzed. These interventions included free instrumental improvisation and song writing and took place in the mid-late stages of the treatment period (Sessions 9, 13, 14).

Prior to this first identified significant experience, O. had been attending music therapy sessions for two months. His feedback had been positive. He often used the musical instruments to “play out” difficult past and present scenarios. He stated that he felt able to speak more freely and openly in music therapy sessions as compared to other therapies. However, upon listening back to the recorded sessions, it seemed that O. was not engaging with the music itself. I felt that it might be helpful for him to understand that he had the option of experiencing a more intense level of musical engagement should he desire to do so.

The following intervention was formulated and discussed with O. There would be three improvisations during which I would play piano and O. could choose whatever instruments he wished. The first improvisation would be slow. I would begin the music and O. could complement this music in any way that he desired. The second improvisation would have the same format except that the tempo would be more upbeat. The rationale behind this approach was to provide O. with the opportunity to listen, feel and differentiate between two contrasting musical experiences without the responsibility of having to provide them. The third improvisation was designated as O.’s opportunity to lead. He would begin and I would provide support.

The first two improvisations lasted for 22:30 minutes and proceeded accordingly. Prior to beginning the third improvisation, O. indicated that he wanted to make noise so that he could “*get out the frustrations of those damn nightmares*”. He initiated loud, solid and steady beating on the conga drums. I joined him on piano. O. had to stop for a moment stating “*I’m gonna hurt my hands!*”. He reinitiated the improvisation with the snare drum. The drumming became very loud; there was no question that O. was the leader and seemed completely engaged. A climax occurred where an ongoing snare drum roll drowned out the piano where I did manage to establish a melodic theme. Near the end of this 8-minute experience, O. was hitting the gong loudly. He then began to play the djembe drum and went back to the gong. He stopped and said, “*enough of this suffering*”. The piano cadenced and the gong faded. (musical excerpt played here)

As the music faded, O. referred to an image of his abuser. He spoke about his anger, memories of being abused (including his first memory) and his anticipation regarding upcoming events where it would be necessary to face these memories. He spoke about the support he had received from others. He discussed family members, his mother's sudden death and remembered difficult conversations and relationships. It is interesting to note that several weeks after this experience, O. mentioned that he was sleeping much better and could not remember having any more nightmares.

An analysis of the responses/dialogue (refer to Table 2) shows that all of the categories/themes, with the exception of references to the music (**B2**), occurred several times throughout the dialogue. Highly prominent themes occurred in Category **C** (personal references /self-expression) where painful events (45 references to **C10**) and expressions of hurt, pain, anger and frustration (21 references to **C5**) dominated the conversation. Other notable areas included 13 identifiable physical responses (Category **A1**), references to others (a total of 27 references in Category **D**) as well as requests for understanding and help (a total of 27 references in Category **E**, themes **14** & **15**).

TABLE 2. O.'s Categories/Themes based on the analysis of the responses/dialogue that occurred during/after 3 identified significant music therapy experiences

| A. Physical Responses | B. Musical References (References to:) | C. Personal References /Self-Expression (Expressions of:) | D. References to Others (may/may not involve self) | E. Request(s) /Desire(s) /Need(s) |
|--|---|---|--|---|
| 1 ...laughing, crying, feeling hot, sighing, pain, biting tongue... | 2 ...the music | 5 ...hurt, pain (physical & emotional), anger (revenge), frustration | 12. References to others' losses, pain, similar situations | 14 ...to be understood, believed, supported, loved |
| | 3 ...feelings /reactions evoked by the music | 6 ...strength, pride, determination (fighting back) | 13. References to /explanations for behaviors, actions, inaction, thoughts, qualities, feelings of others | 15 ...for help (to understand, to get through difficult times, involves more than moral support) |

TABLE 2. O.'s Categories/Themes based on the analysis of the responses/ dialogue that occurred during/after 3 identified significant music therapy experiences

| | | | | |
|--|---|--|--|---|
| | 4. Use of instruments /sounds to demonstrate an idea/make a point | 7... negative self-image, inability, regret | | 16... to live his own life; to accept and move on... |
| | | 8... fear (past, present, anticipation)... | | |
| | | 9... grief, sadness, loss | | |
| | | 10. References to painful events / memories... | | |
| | | 11. References to day to day/normal life... | | |

Comparative Discussion

In the final research paper, comparisons and contrasts were made between the experiences of the two individuals. Areas of discussion included:

- 1.** Significant Experiences and the Therapeutic Process
- 2.** Significance of the Categories/Themes
- 3.** Therapeutic Relationship
- 4.** Roles of Music and Verbal Dialogue

This information may contain elements of transferability if the participants are considered to be typical cases with distinct perspectives. References were also made to the literature.

Discussion and Conclusion

In the final research paper the following areas were also addressed:

1. Methodological Considerations

- Authenticity
- “researcher-as-instrument”

2. Implications for Music Therapy Practice

- Practice Based Research
- Consideration of clients’ perspectives in music therapy practice
- Music therapy with persons who are “actively” living with HIV
- “listening back” to sessions

3. Recommendations

- More research on clients’ perspectives on music therapy experiences
- More research on music therapy and persons living with HIV/AIDS
- Group music therapy for those infected/affected by HIV
- Training considerations for music therapists

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CHAPTER 68

*Perspective of Music Therapy in
Italy: past, present and future. A*

*search for a national
identity.*

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Today's paper aims to present the cultural and professional situation of music therapy in Italy and, by going back over the most important stages in its historical development, to outline some possible paths for the future.

Historically describing the development of a discipline such as music therapy can be a means of asking ourselves about the meaning and the role of this approach to the human condition of difficulty and/or pathology. This is the background question that has by now been posed for several years in the search, not only in Italy, for a definition of the discipline at different levels. Over the years, this debate, which is still very active in Italy, has contributed to recognising and formalising aims, theoretic reference models, intervention plans and areas, methodologies and ethical criteria for the various music therapy approaches.

Since the start of its history, Music Therapy in Italy has developed around intuitions, epistemologies and institutions oriented towards two different areas of cultural reference: the medical/psychiatric-psychological one and the artistic/musical-educational one. For many years these two origins and perspectives of Italian music therapy entered into a heated and conflicting debate for the supremacy of the aspect which each considered to be the constituent and fundamental element of the discipline, specifically the relational element for the first and musical experience for the second.

As in many countries, the first steps of every new discipline always need some pioneers who, in order to be such, must have strong and charismatic personalities which, in the earliest stages of development, are an invaluable resource, also in terms of the intransigence with which more often than not they defend the “orthodoxy” of their thinking.

This process started halfway through the 70s with the first occasion for national comparison at the Bologna Conference in 1973. A few years later Nora Cervi, at the time director of the Music Course of the Pro Civitate Christiana of Assisi and a per-

son endowed with a rare sensitiveness, kindness and far-sightedness, unfortunately recently passed away, made herself the founder, together with a group of collaborators, of the first Italian Training Course which started, as an experiment, in 1981.

For about ten years this initiative was the point of reference for music therapy in Italy, the melting pot for many considerations, elaborations, discoveries, encounters and confrontations. For many of us, Assisi represents the origin, the point of departure from which many of the training and professional experiences that later developed and are currently present in Italy started off.

It was during these first ten years that the debate on the multidisciplinary aspects of music therapy became very heated in the perhaps still somewhat naive search for the “essential component” rather than the most suitable reference “model” or “area of application” for music therapy.

It was still thought that one “music therapy” existed, whereas thankfully over the years it was revealed that many possible and effective music therapies could be identified. During those years there were numerous factors that contributed to the development of music therapy both as an area of practice and as an area of knowledge. On one hand was the growing number of trained music therapists who gradually began to spread music therapy into new areas of application and make it known to other professional categories with whom they were then able to confront themselves and their different areas of knowledge. On the other was the increasing contact with representatives of music therapy in Europe and America who contributed to enriching the wealth of knowledge and theoretical references, also thanks to the increase in the circulation of original and translated texts (for example, the writings, lessons and supervisions of Alvin, Benenzon, Bruscia, Bunt, Lecourt, Nordoff-Robbins, Priestley and Wigram).

Music therapy gradually became a recognised and accredited practice spread throughout the country and music therapists began to be present and appreciated within the various social-educational, rehabilitative and therapeutic teams.

In the commotion caused by such a development it is normal that the more responsible operators start to feel the need for regulation of the profession in order to protect against the use of a proliferation of unreliable figures and defend themselves as professional figures. The first associations emerged which, having also the objective of cultural promotion of the discipline, started to gather groups of professionals at a local level who felt the need for more confrontation within the discipline and to see the recognition of what by this stage was for many their main occupation, but

which often had to be assimilated into more general or different professional roles in order to fit into the various work contexts.

Over the years the form of associations has also become an identifying element in relation to the various positions that are by now widely represented and more communicative in the Italian music therapy field.

The real possession both of good musical abilities and of an psychological interpretative model of musical relationship are by now unanimously recognised as being necessary qualities for a music therapist, though with the different emphasis that the various schools place on one or the other.

Thus, both psychodynamic-oriented music therapies and humanistic-existential relational music therapies currently exist as the two main prevalent directions. The emphasis that is placed on the quality of the musical experience, even within the same orientation, is still rather variable. Other than a good level of musical ability and knowledge, which by now all schools request of aspiring music therapists, for some also indispensable is the quality of the musical experience and a style of encountering this experience that the music therapist must have recognised in him/herself in order to be able to become credible witnesses in the therapeutic relationship. Although not many schools make this request yet, it anyhow seems that this will be the path of future development in relation to the specificity of music therapy compared to other approaches for helping people.

Returning to the historical reconstruction, at the beginning of the 90s the various Regional Associations, which in the meantime had spread considerably, decided to join together to form the Italian Confederation of Music Therapy Associations (Confederazione Italiana Associazioni di Musicoterapia - Conf.I.A.M.) with the objective of including and coordinating the initiatives which were more and more often being proposed in Italy. These initiatives can be classified into the following areas: Informative and for dialogue, Educational, Clinical and Research.

In relation to the first point, information and dialogue, study days, conventions, conferences and publications were promoted on a national level.

In this sense, the Italian Music Therapy Conference took on particular importance. It has been organised every 2 years since 1994 (Ercolano '94, Portoferraio '95, Turin '97, Florence '99, Naples '01, Rimini '03) and allows an internal dialogue and confrontation to be developed between the various positions and practical approaches which are taking shape in the music therapy scene in our country.

The Conferences mentioned have also been an opportunity to distribute publications both coming from the international scene and from the abovementioned lines of thought that are more and more clearly taking shape.

A great deal of attention has been paid to the definition of educational criteria. The Associations have promoted local undergraduates Training Courses as well as some postgraduate experiences throughout Italy. Coordination on a national level has allowed identification of some fundamental criteria for organising the educational programme for the undergraduate courses, circulated via their publication in the Student's Handbook in 1999.

In short, the criteria are the following:

- Length of Training Course at least 3 years (from 700 to 1400 hours);
- Entrance criteria: Secondary school and good knowledge of musical language;
- Educational Programme divided into 4 areas: Music Therapy (45%), Music (25%), Psychology (15%) and Medicine (15%);
- Practical placement (minimum 250 hours) and Tutoring (minimum 60 hours);

The coordination and monitoring of the courses have produced excellent results in terms of educational standardisation. Collaborations and conventions are currently underway between the training courses and music conservatories and universities with the aim of improving the quality of the courses and above all avoiding the danger of self-referencing which is always present in privately managed Courses.

With reference, lastly, to clinical and research areas I would simply like to indicate how far music therapy practice is spreading to more and more varied areas and how this quantitative increase corresponds to a similar significant qualitative improvement also confirmed by the as yet not numerous but still significant presence of research projects which have the advancement and improvement of clinical practice and the application of music therapy among their main aims.

Within this reference framework, the Italian Professional Association of Music Therapy (A.I.M.) was set up in June 2002.

The association's main objectives are the recognition of the professionalism of those who work in this sector and safeguarding the correct practice of their profession.

Among the various aims that the Association has set itself we would like to point out the following aspects:

- Managing a National Register of Music Therapists comprising three sections: List of Music Therapists, List of Music Therapy Educators and List of Supervisors;
- Establishing and raising clinical and ethical standards;
- Being a constant point of reference for all music therapists in Italy;
- Guaranteeing the correct practice of the profession by the members of the Register;
- Safeguarding the collective interests of the sector providing consultancy and support;
- Encouraging the spread of updated information on job opportunities and new work agreements;
- Encouraging the exchange, publication and distribution of works relevant to music therapy;
- Establishing and maintaining contact with other music therapists and associations around the world;
- Maintaining a continuous relationship with the other related professional associations.

In the pursuit of these aims, a ‘Collegio Probi Viri’ has been nominated which will verify that the registered professionals observe the standards in the Code of Ethics.

Of particular importance is the fact that 3 specific Registers (Music therapists, Teachers and Supervisors) have been identified, and the relative entrance criteria for all three Registers have been identified and defined:

REQUISITES FOR INCLUSION IN THE REGISTER OF MUSIC THERAPISTS

- To have obtained a Diploma in Music Therapy from a training school recognised by the A.I.M.;
- To have carried out, after the Diploma, at least 60 hours of Supervision with a Supervisor recognised by the A.I.M. over a period of at least 12 months and in reference to your own clinical work;
- To have passed a qualifying examination consisting of a written test analysing a case (preventive or rehabilitative);

-
- The criteria for permanence in the Register have at present been identified as a minimum of 30 hours of professional updating courses to be carried out during the three years of membership of the Association.

REQUISITES FOR INCLUSION IN THE REGISTER OF MUSIC THERAPY TRAINERS

- Having a Degree (in medicine, psychology, social-education, music and Conservatory)
- Having been in the register of music therapists for at least 5 years
- At least 5 years of professional work (at least 1600 hours in total)
- At least 60 hours of supervision (5 years under the responsibility of an A.I.M. supervisor);
- At least 2 articles or publications on music therapy and published in contexts of the medical, psychological, social-educational, musicological and music therapy sectors.
- At least 1 paper on music therapy presented at national or international conferences

REQUISITES FOR INCLUSION IN THE REGISTER OF SUPERVISORS

- Having a specialised Degree (in medicine, psychology, social-education, music)
- At least 10 years of supervised professional work with permanence in the A.I.M. register
- At least 5 articles or publications on music therapy and published in contexts of the medical, psychological, social-educational, musicological and music therapy sectors.
- At least 3 papers on music therapy presented at national or international conferences
- At least 2 years of personal dynamic music therapy in a small group or individually (40 hours annually); alternatively, 2 years of individual psychotherapy c/o a professional accredited by a psychotherapy association recognized by the State.

Currently the Association numbers approximately 150 members evenly distributed throughout the country and coming from all of the various Training Schools;

Although it is not the only professional association existing in Italy (at the moment two associations are registered in the EMTC), the A.I.M. currently represents as a body the highest number of music therapy professionals from various orientations. It is present and active in the process of recognition at a national legislative level within the CNEL (Consiglio Nazionale Economia e Lavoro - National Council for Economy and Labour). The association's aim is that music therapy be counted among the new professions in the socio-medical sector whose practice will be regulated and recognised by the respective professional associations who have been entrusted with this task by the government.

In reference to this important objective of the express Recognition of Music Therapy, we would like to briefly outline the problem, to go over how this process has taken shape in our country and to identify the path that can lead to obtaining this recognition.

The intellectual professions, of which music therapy is one, represent the most dynamic and growing part of the labour market and the professional competences represent a fundamental element of modern social organisation.

For these reasons over the centuries the intellectual professions have been protected by legislation in which corporative interests and the government's desire for control coexist in an alternation of government activism and autonomy.

The origin of the regulations, created via professional Rolls and Registers, is found in the recognition by the government of a specificity of the intellectual professions and their ability to have an effect on interests central to the stability of society.

At present, the fragmentation of knowledge has made new needs emerge: numerous new professional figures have joined and are joining those who have traditionally had recognition and regulatory control.

In a versatile and continually changing context, the professional system in our country thus calls for significant revision, reorganising and regulations.

The existing professional Registers must accept the idea of modifying their structure in order to update and adapt them to recent transformations in the professional world while we will have to continue with the recognition of the representative bodies (Associations) of just as many professional activities.

Bodies that can guarantee suitable levels of qualitative control regarding professional competence and ethics.

The debate that has gone on at a professional level between the sectors involved has allowed an important agreement to be reached on some basic principles of the reorganisation of the professional system in Italy.

Numerous Bills, proposed by the Ministry of Justice which has jurisdiction on the matter of the regulation of Professions, refer to a general reorganisation of professional aspects and mention the Professional Associations as bodies that can identify, maintain and raise the Professional quality practiced by the individual Associations.

As all the elements required to proceed have been acquired during the previous legislation, the logic of the matter would have Parliament approve the Reform for the Recognition of the professions in a reasonably short time.

This Recognition would lead to the entry of the Association in an appropriate register, under the care of the competent Ministry, followed by a verification of the requisites of the recognised Association.

Conclusion

In conclusion, we would like to emphasise that the process largely identified anticipates that the educational aspects, entrusted to the Conf.I.A.M., and professional practice, entrusted to the A.I.M., must translate into complementary and communicating aspects of a single reality which aims to improve the professional quality of the music therapists involved.

This quality is maintained and raised through the ability to listen to the general problems of members and to meet with them in the face of difficulties in the practice of the profession as well as taking care of and encouraging the exchange and spread of information.

It is in this direction that the A.I.M. and Conf.I.A.M. have organised for this occasion a special issue of the journal which brings together some of the projects from the last few years in English as an exemplification of what we have illustrated here.

We would like to highlight that, pending a definitive recognition of the music therapy profession following the approval of the special Bill, the process so far identified will in any case have an immediate effect on internal regulation and recognition.

The creation of a Register in which people who have followed an accredited Training course and have started to practice the profession following quality certification criteria can enrol is a sign of seriousness and maturity that allows us to think optimistically about the path that will lead to Recognition.

A valid process of Professional Recognition can be planned and carried out by bringing the best human resources into play with the firm belief that, as clearly highlighted in the Directive issued by the European Community, they are proposing a useful service to the clients, from socially fragile areas, that music therapists devote themselves to in their work.

As we all well know, the search for identity is a dynamic process with many steps to be covered. Just as it is useful at times at a personal level to become more aware of the distance you have travelled in order to have the trust and respect for the part you still want to travel, also in the search for a dynamic identity for music therapy in Italy we are aware of not being so small any more and of having covered a demanding but important stretch of road..... and, jointly, of really wanting everything that is still left to do and to discover.

We would like the spirit with which we will travel the “next part” to be a bit less dictated by demanding and idealistic contrasts and much more abounding in mutual listening and cooperation.

As always in our work words convey the sense of an experience that we have lived or that we want to live much less than music. We would like to conclude with a piece of Italian music in which each of us can find echoes from the past and signs for the future.

CHAPTER 69

*Music therapy with
adolescents in Italy*

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Introduction

In this paper we would like to present some reflections on the music therapy project that we have been carrying out for some years with adolescents for MusicSpace Italy, the Italian branch of The MusicSpace Trust.

Although a daily habitual contact with music seems to be one of the key identifying features of adolescents of our times (IARD 1996) it has only been in the last few years that music therapists in Italy have turned their interest to this important transitional phase of life in developmental and psychopathological contexts. Since the 1980s there have been numerous studies and research projects in the fields of musicology and psychology of music on adolescence and music, but it was only towards the end of the 1990s that the first accounts of specific music therapy projects appeared in Italy with adolescents in psychiatric day centres and in situations of

risk of deviancy in school (Zanchi 1999, Violi and Draisci 2000, Cordoni 2002) as well as young drug addicts with associated mental disorders (Postacchini 2002).

Our work was one of the first experiences in Italy of music therapy with adolescents attending psychiatric day centres and in situation of communicational and behavioural problem in school.

Over the last seven years this experience has involved 220 young people aged 13 to 18, mostly males.

Adolescence and music

The meeting between an adolescent and music can develop along extremely variable paths resulting from the numerous ways in which the typical features of emotional and mental functioning at this age interact with forms of musical experience .

One of the most vivid features of adolescence is the experience of the loss of the childhood that the adolescent is breaking away from, an experience which proceeds in parallel to the frantic search for confirmation and reassurance of their sense of identity and of their future. Tendencies to idealize and over-intellectualise aided by the maturation of cognitive processes are combined with an emotional-affective level that is still very unstable. Together, these produce a widespread state of confusion and ambiguity between developmental stimuli and regressive tensions (Meltzer 1981).

This aspect of unstable self-perception leads the adolescent to seek a group of peers as a model and container for his/her very important “proofs of identity”, as a place of reassurance / validation and as a group to compete and compare himself against. (Ricciotti 2004). It is in precisely this context that, for an adolescent, music takes on a function of reinforcement of personal identity and of mediator and facilitator for interpersonal communication. At times, music may also act as a catalyst for the dimension of wanting to belong and cause a renewed investment in the world which can rescue the adolescent from the dangerous tendency to withdraw into himself.

The other part of our interest is the structure of the musical dialogue, its form and some elements which we consider relevant in understanding the relationship that adolescents enter into with music.

In recognising the sense of a musical work, elements connected to its origin and the processes put into action by the listener jointly come into play.

Music does not only carry acoustic information; in fact, every human being recognises different emotions, thoughts, sensations and images in music. Music does not signify, but it suggests; it has a sense but not a meaning (Imberty 1986).

Furthermore, built into its structure, music has the ability to relate contrasting and ambiguous elements, conflicting themes, temporal and dynamic contradictions, stimuli that are multiple and non-specific at the same time, without being forced by its nature to make a choice and without jeopardising its communicative power (Gaita, 1991).

To translate musical sense, each individual thus proceeds in his own way through the always-different experience of the subjective meeting between musical form and mental life (Ricciotti, 2000).

“Unlike verbal language, music and art offer the client a language which does not indicate meanings in an unequivocal way, which does not define but which, through the analogical power of symbols, suggests connotations with multiple, open meanings. It would appear that this polysemy of the languages of the arts inevitably coincides with some of the typical traits of adolescence and allows the coexistence of apparently contradictory thoughts and states of mind, activating projective mechanisms which tend to fill the ambiguity of the form of the stimulus with mental and emotional elaborations” (Corraini, Zanchi 2001)

From the study of some of the typical ways in which adolescents use music it was seen that these ways sometimes correspond to precise personal features, listening and lifestyles. In general, a fluctuation is seen between more passive and more active extremes, or between a more consumerist type of use and a more creative one (Manarolo 2004).

For a certain type of adolescent, in fact, music represents a space in which impulse and a lack of criticism, the influence of fashion and abandonment to excitement and amazement are predominant. He looks for music which stimulates the senses, that he can merge with and which envelops his body, not leaving any spaces which could let him feel his needs and tension. The main listening style is observed in a regressive state and is linked to the type of functioning as in Bion's basic assumptions as well as to defence mechanisms such as schizo-paranoid type, adhesive or projective identification; space for symbolic elaboration is not tolerated at all.

This listening behaviour is characterised by stasis, lack of change and immobility, also obtained as the paradoxical result of repeated and stereotyped movements. Symbolisation and individuality disappear and there is a massive activation of the background in the form of circular, empty repetitiveness.(Tagg, 1993).

The experiences of escaping from reality and desynchronisation from the spatial/temporal perception of daily life that are sometimes caused make this modality of using music similar to some toxicomania behaviours.

Another possible means of using music concerns those adolescents who consider music to be an opportunity for self-expression, for healthy retreat from ordinary thoughts, for identification with the writers singers, for choice and for refining their own artistic sensitivity. This relationship with music becomes manifest when “the desire and the ability to sort through the mass of sensations which the sounds stir, acquiring, as the final stage in a hypothetical journey, performance and creative skills” manages to emerge from the more passive means of using music (Frontori, 1992).

This time the listening style occurs in a progressive state and is connected to a type of functioning which focuses on the completion of a task and which uses defence mechanisms such as introjective identification corresponding to a mental position that is more elaborative and sufficiently harmonious to be able to attune to the real profundity of another person’s feelings (Postacchini et al., 1997).

This different type of behaviour is characterised by openness to the idea that listening can bring about a change, the capacity to recognise variations and an interest in identifying formal elements in the musical dialogue. There is the possibility to perceive those “happy forms” or qualities of music (Gaita 1991) that can directly evoke feelings and emotions through symbolic association.

Experiences with the adolescents

The music therapy project that we are going to illustrate specifically emerged from our interest in investigating the styles of relating to the musical experience, listening and playing, with the hypothesis that these styles might correspond to as many different, more or less troubled lifestyles. For a young person to enrich the quality of her/his relation with the musical experience may sometimes represent the only way to discover new “styles” to relate to herself/himself and to the world.

On previous occasions we have looked at the clinical projects (Zanchi, World Conference Proceedings, Oxford 2002) which since the end of 1997 have involved approximately thirty adolescents who regularly visit a psychiatric day centre in the North Italy and who suffer from serious psychopathological disorders; on this occasion we would like to focus our attention on music therapy projects carried out with young people in secondary schools. These projects, which were started up after the clinical-therapeutic projects, were of short to medium duration (from four to ten sessions) compared to the earlier ones (from one and a half to three years with weekly sessions) and were carried out in a group setting rather than an individual one.

Far from wanting to integrate such different experiences, our intention is to reflect on the possibilities that music therapy can offer in the identification and optimisation of personal listening styles in the belief that it can significantly influence the self-organisation of life styles and give rise to an expressive and creative desire, especially in adolescence; this is both in situations of psychopathological disorder and not.

The music therapy groups with the adolescents

This music therapy experience was started up in the Technical High School in a town in Central Italy, and it goes back to a pilot project set up three years ago as a result of the need to find strategies to prevent the problems and maladjustment which often cause situations of high drop-out rates from school and forms of juvenile deviancy. The request for intervention came from the school's management and the teachers with the aim of improving their increasingly difficult and demanding communication with students.

Due to a cultural/social background which is not very considerate of adolescent problems and rather isolated geographical origins, the young people who go to these schools often have trouble expressing themselves and, in particular, they find it difficult to use verbal means to voice their experiences, tastes, desires, disquiet, anger and anxieties. These experiences either emerge via a lack of control or through strong inhibitions, both situations that do not allow the person to acquire formative tools which are useful for a harmonious growth process.

More and more often, the only solution these young people find to the problems mentioned above is giving up school early. As in many other European countries,

our country has registered the spread among adolescents of aggressive behaviour and a growing difficulty on the part of educators to implement effective strategies.

More and more often, teachers request interventions of support for teaching activities due to the growing difficulty in relating to these youngsters. They request supplementary projects which require the presence in the school of experts in the field of relationships and communication in order to find new tools for improving the quality of relationships with and comprehension of their students.

The project started in Autumn 2001 with a preliminary investigation carried out among the students of about ten classes in which an open question was set to gather information on the representations that the adolescents had of their personal “experiences” of music (H. Smeijsters in Wigram, Sperston, West 1995).

In all, the interview involved 110 youths between 15 and 18 years of age.

The request made was to write the sensations, emotions, sense, or simply whatever came to mind following the sentence: “When I listen to music...”

The time available to write the answer was five minutes and anonymity was guaranteed.

While studying the replies we intended to define a hypothesis on the main styles of use of musical experience in the adolescents, a central element that we intended to investigate and work on later in an interactive musical way. The answers that could be attributed to consumerist and not very elaborative listening / use behaviours were by far predominant. Below we have recounted some of the answers obtained:

**GROUP FOR WHICH MUSIC IS ABOVE ALL A SPACE WHERE
IMPULSE AND LACK OF CRITICISM, ABANDON TO EXCITEMENT,
AMAZEMENT, THE INFLUENCE OF FASHION AND A MORE PASSIVE
EXPERIENCE ARE PREDOMINANT:**

“WHEN I LISTEN TO MUSIC.....”

- I sing, I shout, I relax (Luca, 15)
- I remove all the worries from my mind. I don’t think about anything. (Andrea, 16)
- It depends what I’m doing. If I’m lying on my bed I fall asleep more easily, if I’m playing car games on the computer my adrenalin level goes up and I let off steam trying to corner like a madman. (Maurizio, 15)

- It blows my mind (Mauro, 16)
- For me, listening to music is also a chance to relax, actually I should say most of all a chance to relax because I usually get a sensation that almost seems like not thinking about anything. (Luca, 17)
- When I listen to music I feel good, I feel like I'm flying, I'm in a world of my own with my thoughts and I get really worked up, especially when it's disco or Latin American music. When I listen to music I start to daydream about the piece I'm listening to. Music makes me feel at peace, with myself and it makes me forget school, tests, homework, etc. for a moment.

I think that music is essential in the life of a teenager. (Francesco, 16)

- My mind frees itself of the thoughts *that worry me during the day*.
For me, music causes a period of relaxation that starts from my head and then goes right through my body.
For me music is life. (Andrea, 17)
- I feel better, like I'm in another world, I don't think about my problems any more. Each type of music I listen to matches one of my states of mind and one of my fantastic fantasies. Even my sadness, immersed in music, disappears and I can think better. (Marco, 17)
- First of all, depending on the day I've had or I have to face I listen to a certain type of music. If I have to gear myself up I put on "aggressive" Rock or if I'm down I put on a calmer kind of music, always strictly Rock. (Domenico, 18)
- I get sentimental. If I'm in a bad mood and I listen to "tranquil" music, I calm down. Different kinds of music change my feelings.
There are so many things to say that a whole exercise book wouldn't be enough.
So, I like music! I like it a lot! (Giovanni, 17)

GROUP FOR WHICH LISTENING TO MUSIC AS AN OPPORTUNITY FOR SELF-EXPRESSION, DECENTRALISATION FROM ORDINARY THOUGHTS, IDENTIFICATION WITH THE SINGER, A MORE CREATIVE EXPERIENCE IS PREDOMINANT

"WHEN I LISTEN TO MUSIC....."

- When I listen to music I think that *I am* the singer, I'm on a stage with millions of people and I feel like I can hear the audience applauding me and loving me, screaming my name at the tops of their voices. It makes me feel important. (Andrea, 16)

- I feel better and I enjoy myself, I experience extraordinary emotions and I think about the singer's emotions and I feel them in me. (Paolo, 16)
- I can *take on different identities*, I mean, if, for example, I'm lying on my bed I relax, or if that particular music reminds me of something important, I think about it again in lots of different versions.

On the other hand, when I'm doing a physical activity I can load myself with adrenalin (at least I think so) and as a result I can work for longer at the peak of my motor abilities.

Still other times, depending on the work I'm doing, I can concentrate at my best. For example, I think: if it's a love song, about a girl, if it's about a journey I would listen to it all the time, because I identify with the *journey* that the singer has written. (Filippo, 17)

- I travel in my mind.

I feel really strong emotions being stirred up in me, to the point that I start to sing, thinking about the things that have happened to me before in my everyday life.

- I live. I feel free from any dogma, I am free to think whatever I like.

I play and this allows me to leave all my problems behind me.

I listen to everything: from opera (Carmina Burana) to metal (Anastasia, Rap-sody), they are very different from the usual kinds of music because they have an orchestral base, but played with instruments that are used in Metal.

This *characterises me* and at times it *isolates* me.

But when I find someone who listens to my kind of music I feel closer to them.

For me, music is art and I'm starting to compose by myself and my friend's opinions are very positive.

My dream isn't to be famous, but to play wherever I get the chance and to be respected by great artists. (Fabio, 17)

From the observations that emerged from the replies, we put forward the hypothesis that an **expressive music therapy project** using mainly non-verbal mediation could represent an experience of facilitation of expression and communication also at a verbal level, of education in listening to themselves and others in a more elaborative way and of increasing of self-esteem and enhancing of personal qualities.

The model we referred to was that of **interactive music therapy** which is related to the **free improvisation therapy** in a humanist-existential psychological frame of reference. The project anticipated the involvement of one active music therapist and one in the role of supervisor.

The subsequent stages of the project involved, **over three years, 86 males from 15 to 18 years of age** in group music therapy projects. The boys who were recommended for and referred to music therapy by the teacher class committee, and therefore with the agreement of all curriculum teachers, were representative of the most difficult situations in the whole school.

All of these adolescents showed strong relational difficulties and communication problems; often involved in aggressive incidents, most of them showed themselves to be intolerant of the teachers and by this stage indifferent and resigned to their very poor school results. For many, giving up school seemed certain at this point. Some of them showed clearly deviant behaviour.

A smaller percentage of the youngsters, however, in almost a mirror-image, showed strong inhibition and withdrawal; also withdrawn in their posture, they almost couldn't utter a word and were often isolated from the group when they weren't being mocked without any chance of reacting.

We began the active music therapy sessions, carried out from March 2002 to May 2004 with groups of different young people in the periods and arrangements summarised in the following table:

| | | | |
|-----------------|--|---|----------------------------------|
| Mar-May 2002 | Industrial Technical High School | 1 group / 10 boys Different classes Age 15-17 | 9 Mt sessions; 1 hour a week. |
|-----------------|--|---|----------------------------------|

| | | | |
|-----------------------|--|--|---|
| Nov 2002- May 2003 | Industrial Technical High School | 5 groups / 8 boys each Different classes Age 15-18 | 9 Mt sessions; 1 hour a week. |
| | | 1 group / 20 boys Same class Age 15-16 | 5 Mt sessions; 1 hour a week. |
| Feb - May 2004 | Professional High School | 1 group / 16 boys Same class Age 15-17 | Interview/Open question: “When I listen to music..” 6 Mt sessions; 1 hour and 30 min every 2 weeks. |

One further element that we considered to be important in organising the project was an individual introductory interview where the music therapist presented the project to each student and tried to gather useful data for the definition of his “musical profile”.

Where a class group had been referred the interview was carried out with the whole group.

The commitment was “free” with the possibility to withdraw from the experience at any time. The families were informed and gave their consent.

In total 99 people were contacted of which 86 agreed to and completed the project (8 did not attend regularly). This high percentage of participation in the project undoubtedly influenced the time at which the sessions were held: the young people actually met with the music therapist during school time (lesson time). In order to carry out the sessions during school hours the collaboration of the teachers proved to be essential, a factor which gave the students who participated the sense of an experience which was not unrelated to and detached from their educational itinerary in school.

Observations and remarks on the music therapy process:

In the various group projects, the **first sessions** were generally characterised by a somewhat variable quality of verbal communication: very limited in the case of the more withdrawn and inhibited students, constantly present in the case of the group characterised by a more intense and “noisy” style in which there was a strong need to fill every silence with words or noises.

The participants responded positively to the music therapist’s first requests to present themselves using an instrument: almost everyone agreed to play, immediately approaching the instruments. The choices of instruments were somewhat varied: the large percussion instruments (tumba, congas, djambé, bongos...) were chosen by a higher percentage and were preferred by those who showed characteristics of aggressive behavioural intensity which was difficult to handle. These characteristics, already evident within the class, found expression in music through strong, imposing intensities that were sustained for long periods of time, especially during the first sessions. The request from these youngsters through music seemed to be for visibility and acknowledgement of their leadership.

This type made up a significant part of the percentage of the students who had been indicated by the teachers as being “difficult” to handle within the class.

A smaller percentage also showed an immediate approach to the instruments, but in a way that was characterised by lower sound intensity, the choice of smaller-sized instruments and greater variability in the choice of timbre. The gestural expressiveness of this second group in the production of sounds was very controlled and characterised by small movements. The instruments appeared to be used in a more defensive rather than expressive way; their improvisations seemed to more centred on themselves but at the same time they let key individual stylistic features filter through. It goes without saying that often these students were completely dominated by the high intensity of others and it was difficult, also for them, to listen to what they were playing.

In this second group of youngsters the choice of instrument was more varied over time, although a sort of identifying instrument in which they could recognise themselves did seem to emerge for each student. During one session Giacomo, a 16 year old boy who was extremely closed to relationships and had a passive attitude in class, was playing a small egg that he had repeatedly chosen and said: “I’m like this”.

During the first sessions the music therapist’s sensation was that she was able to represent for the group a sort of “scapegoat” upon which they could heap much of the frustration built up over the years, especially in school. She felt that she “per-

sonified” the school institution and the difficulties experienced there every day: in one of the first sessions in one of the groups a boy turned up asking to listen to a song by Giorgio Gaber. Listening to this piece in the group, the singer’s voice, which explicitly asks adults not to “teach their own outlook on life” to their children but to give them the possibility to make choices and mistakes by themselves, made a strong impact on everybody.

On the whole, the **group improvisations in the early sessions** were characterised by a high level of sound intensity and by the quick attuning of the group to elements of rhythm and pulse that it was difficult to diverge from. These rhythmic elements were sought in the group’s shared repertoire using criteria of similarity and identification.

Another feature of the early sessions was the boys’ “background noise”. They had difficulty not filling moments of silence between one improvisation and another with words, laughs, mutual teasing and jokes, allowing their difficulty in maintaining the aspect of listening to what had been created and their need to fill these moments with various types of sound to show through.

During this phase, spaces for symbolic elaboration of the experience were few or none.

The role that the therapist felt she should cover in the first part of the sessions was more geared towards “guaranteeing” and safeguarding each person’s individuality: of the more vulnerable and less audible youngsters at a musical level by paying attention to the “pianissimi” and the nuances present but less evident, but also allowing the “noisier” participants to give a problematic but not destructive form to their intensity.

Though still without making too many proposals, in this phase the music therapist listened and supported the free expression through improvised music of the individual characteristics of each student. Slowly and gradually we assisted to a decrease in the expressive “urgency” that had been shown by the youngsters and a perceptible acceptance of new proposals from the therapist was observed.

These proposals were largely centred on techniques of turn taking and of the figure-background, solo-tutti relationship. The very louds and very softs were gradually enriched with varying degrees in between.

In the central sessions of the various projects, the improvisations acquired referential aspects which were previously completely absent: more and more often the par-

ticipants gave their improvisations titles both before and after playing them, on the one hand highlighting the capability to give musical shape to an experience and an emotion while on the other being able to identify and recognise these in the musical expression of a performance. (Noise>To Pour out; We are black> We are grey, Freedom>Happiness; Differences>Respect; We are fed up with school>Let's go away).

The gap between one improvisation and another began to empty of background noise and, although with difficulty, some sensations and reworking of the experiences created together were able to emerge.

This shouldn't lead you to think that the stylistic aspects, both typological and musical, of the youngsters had changed, but rather that, from this moment on, they found a different way of identifying with and encountering each other.

It was in this phase of the various projects that some of the youngsters shared the nature of their problems with the group and how these were difficult to live with in the school environment.

Identification of the boys between their poor results in school and their own self-esteem also emerged.

The therapist's sensations in this phase were of being recognised more for her own stylistic and musical characteristics, losing the connotation of an "adult from the school".

As the sessions progressed a change was observed in the style of listening to their own and their companions' musical productions: the improvisations took on a more dialogic character with an increase in listening to musical proposals and responses and more reciprocal play was possible in the figure-background sequences. On a musical level, moreover, greater willingness was observed to take turns in the role of leader and to acknowledge different styles of musical leadership. In the last few sessions, the quality of the verbalisation following the improvisations also confirmed the shift towards a more introjective and elaborative type of listening and participation.

In most of the groups, following the music therapist's suggestion, the students kept the **last session** for proposing listening to pieces identified as representative either of recent individual experiences and/or of the experience they had had together. Listening to these proposals, which were of various genres and styles but were mainly rock, was almost always characterised by an atmosphere of mutual listening

and respect, even in cases of somewhat different tastes. The therapist also chose and proposed a piece for the group to listen to from the classic repertoire.

The end of each cycle of sessions was followed by a meeting of the music therapist with the teachers and, where possible, the parents.

One of the first comments to make was that this type of process was more evident in the groups made up of young people from different classes. In the music therapy groups formed by class groups, and also with a higher number of participants and a lower number of sessions, the work was less expressive and more sclerotic in terms of group dynamics. The roles of the youngsters within the class were better known and it was more difficult to break away from this in order to find new possible equilibriums.

Of the 70 youngsters who participated in the music therapy groups till 2003(the last 16 are now ending the school year) we have now a follow up about 50 of them. Among these 50 boys, 7 left the school. Unfortunately we cannot compare this data with previous one we never had.

The next year to each group project, the music therapist asked some information about the boys to some of them teachers. In many occasions the teachers observed that generally they were more expressive and communicative and that they were more able to cope with frustrations, even those boys that were not successful at the end of the school year and decided, anyway, to continue.

Conclusions

We would like to conclude our work with some reflections on the sense that we think an experience of music therapy can have for adolescents in various contexts. The experiences carried out in clinical situations, presented on other occasions, and these latest experiences carried out in schools would appear to confirm that for many adolescents the maturation and enhancement of their means of relating to music can, more than other approaches, contribute to the restructuring and development of the relationship that the subject establishes with himself and with the world.

The specificity of the restructuring role that musical experience can perform with adolescents compared to other therapeutic approaches seems to lie in the constituent features of music itself which, as we have already said, is capable of offering

many different things to a young person, different but simultaneously present. Perhaps even more important is the offer of freedom to listen to and acknowledge what in that moment is the “thing for me” without the music suffering from it.

It seems to us that, in his relationship with music, an adolescent can come into contact with the place where the simultaneousness of contradictory states can be encountered and lived in a less dramatic and paralysing way, but rather where he can allow the more mature parts of himself to evolve and the still insecure parts to wait, acknowledging the dignity and “mutual empathy” (“*simpatia*”) of both.

The way “how” this acknowledgement is carried out characterises what we define “style” and we consider the true testimony of the identity of the person in the here and now (Gaggero, 2003), a dimension of wholeness and integration, that dimension of “sense” that music can connect or reconnect with.

In this experience with the adolescents we saw that being able to be reached, without words, where they were, as much within a chaotic and overwhelming intensity as imprisoned by a repetitive and stereotyped rhythm without these experiences having to be put into categories of “right/wrong”, often proved to be the only possible starting point for exploring “variations” which up to that point were felt to be impossible or unacceptable.

We can think of several moments when the rhythm was accepted as an opportunity to reveal and recount an internal tempo perceived either as “too” slow and feeble or “too” fast, intense and unsettling. That which in life can be painfully experienced as “too much” or “too little”, in music can take shape and, even better, define a personal style. Therefore we have music that is organised around a slow and heavy pace, alternated by long silences, and which can give voice to the nature of that condition.

Just like the strong intensity, which on a behavioural level often erupts into painful actions, often took shape in loud, percussive improvisations which only with great difficulty managed to conquer a moment’s silence but which, in this state, were able to offer a shareable and somewhat reassuring sound representation.

We have observed how important this offer is in a clinical situation with psychopathological problems where, in the most successful cases, the experience of restructuring the relationship with music encourages and corresponds to a structural reorganisation of disharmonic elements of the personality; in the schools described in this work the music therapy experience showed its “preventive” worth as regards risk factors in adolescence.

A constant that we observed in all areas of work with adolescents is that, through a suitable relationship with music, the body, the emotions and the thoughts can start to communicate with each other again via a channel which includes them all but which can also save a space for greater emphasis on one of them without excluding the others.

It is in this moment that we often witness a re-orientation of desire for the world, for a story that can be written or, if interrupted, can gradually start to develop again.

The language that can allows an adolescent to talk about herself/himself is no longer the language of childhood; it is made by a new tastes, new words, new style that she/he doesn't yet know.

This new style cannot be "taught" we can accompany youngsters, motivating them to discover and listen to it and to clothe it in "their" creative will.

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